
NEW YORK STATE
EMERGENCY MEDICAL SERVICES COUNCIL
(SEMSCO)

Wednesday, February 18, 2009
9:00 a.m.
Crowne Plaza
Lodge Street
Albany, New York

APPEARANCES:

Donald Faeth, Chair
Nancy Benedetto
Richard Brandt
Arthur Cooper, MD
Paul Cousins
Tim Czapranski
Warren Darby
Robert Delagi
Donald DuVall
Phyllis Ellis
Vincent Faraone
Debra Fults
Deborah Funk, MD
John Hasset
Mark Henry, MD
Bradley Kaufman, MD
Andrew LaMarca
Alan Lewis, Sr.
Michael Mastrianni, Jr.

Michael McEvoy, PhD
Michael Quinn
Walt Reisner
Storm Treanor
Colleen Vesely
Michael Washington
Edgar Wedge
Edward Wronski
Mark Zeek

1 MR. FAETH: Well, good
2 morning everyone. If everybody
3 could please grab a seat, I'd
4 appreciate it. And if you could put
5 your cell phones on vibrate or off.
6 Same with the pagers. I'd also
7 appreciate that.

8 Valerie, would you like to
9 start with roll call?

10 (Roll call taken.)

11 MS. OZGA: I just have a
12 few announcements I'd like to make.
13 The first thing is, if you were here
14 yesterday, we do have a validation
15 stamp for anybody who is parking in
16 the garage. Just see myself or Lisa
17 by the end of the meeting and we'll
18 get yourself all situated.

19 Also, I think there was a
20 little confusion on the dates for
21 2009. I sent out an e-mail just to
22 let everybody know the September
23 dates were changed to September 8th
24 and 9th. So I know there's been a

1 couple different dates floating
2 around, but the meeting is September
3 8th and 9th. Thank you.

4 MR. FAETH: Thank you,
5 Valerie. I hope everyone had an
6 opportunity to look at the minutes
7 from the last meeting for December.
8 I know they were not available in
9 hard copy this time around, as they
10 probably won't be coming forward
11 through the year. But if you did
12 have the opportunity to look at it
13 online, do I have a motion to accept
14 the minutes as they were stated?

15 MR. LEWIS: So moved.

16 MR. FAETH: Motion by Al
17 Lewis.

18 MR. ZEEK: Second.

19 MR. FAETH: Seconded by
20 Mark Zeek. All in favor?

21 SPEAKERS: Aye.

22 MR. FAETH: Against?
23 Opposed? Ayes have it. Thank you.

24 Before we move forward into

1 the agenda, we had two tragic events
2 within the healthcare community this
3 coming year. We're going to have a
4 moment of silence for volunteer EMT
5 Mark Davis and Dr. John Pryor.

6 But before we do that, I
7 believe there are two individuals
8 that would like to speak a little
9 bit about each. Dr. McEvoy.

10 DR. MCEVOY: Ed can go
11 first.

12 MR. WRONSKI: Okay. Thank
13 you. I'd just like to say a couple
14 of words about Mark Davis. Mark
15 Davis was a twenty-five year old
16 young man who worked up in the St.
17 Lawrence Seaway area. He -- from
18 all accounts that I have, and these
19 are from a variety of sources, he
20 was a very well liked, enjoyable
21 human being to know and to work
22 with. And I have that from his
23 instructor, from Deb, who knew him
24 as well, and from others.

1 He volunteered with, I'm told,
2 five separate agencies, mainly EMS
3 but also fire. Very committed to
4 supporting his community and being
5 available for calls whenever they
6 happened and whenever there was a
7 need. He did not shirk at taking
8 transfer calls when they occurred in
9 the middle of the night, whenever he
10 could get the practice and the
11 ability to work with patients. He
12 apparently enjoyed that very much.

13 He was attending paramedic
14 school. He hoped to be a paramedic.
15 Unfortunately, he did not at that
16 time. At the request of the county
17 EMS coordinator and others, the
18 Department, with the Commissioner's
19 permission and signature, did issue
20 an honorary paramedic certificate to
21 Mark Davis. That was presented to
22 his family.

23 I would like to say Mark
24 represented what we hope to find in

1 EMS in the future, young people
2 committed to their patients,
3 committed to the community. Because
4 what we saw as a response to his
5 loss was EMS coming out to not only
6 attend the funeral and the wake, but
7 to also pull together to cover the
8 territories of the agencies that
9 Mark worked with and others so that
10 they could go to the funeral and pay
11 their respects.

12 But they're small agencies.
13 They have one ambulance. They have
14 a small number of crew members. And
15 so agencies from other counties
16 voluntarily sent people up and rigs
17 up to cover the 9-1-1 calls during
18 the period of time that respects
19 were paid to Mark Davis. And I
20 thank them very much for that.

21 I had some of my staff there
22 and I thank them, but I particularly
23 thank and honor Mark Davis and the
24 unfortunate loss of this young man

1 during an emergency call.

2 Which, if some of you don't
3 know, is doubly tragic, because he
4 was actually murdered during a call
5 and that has not happened in state
6 history other than September 11th.
7 But this was one individual and
8 patient who committed this act.

9 So I'd ask now if Dr. McEvoy
10 could talk about Dr. Pryor.

11 DR. MCEVOY: I would just
12 like to ask for a moment of
13 remembrance for our colleague,
14 friend, student, teacher and really
15 a true American hero, Dr. John Paul
16 Pryor, the trauma program director
17 for the hospital of the University
18 of Pennsylvania in Philadelphia, who
19 was killed by enemy mortar in Iraq
20 on Christmas morning 2008.

21 John was a member of the
22 Pennsylvania SEMAC. He was the
23 editorial advisor for the Journal of
24 Emergency Medical Services and on

1 the board of directors of the
2 Greater Philadelphia American Red
3 Cross.

4 John was born and raised in
5 New York State and he was attracted
6 to medicine by volunteering at my
7 home ambulance corps, Clifton
8 Park-Halfmoon Ambulance just a few
9 miles north of here. He finished
10 medical school and his surgical
11 residency at the University of
12 Buffalo, and like many New Yorkers,
13 John was deeply influenced by the
14 attack on America on September 11th.
15 He spent two days working on the
16 pile in the City.

17 And subsequently, in his own
18 words, John told us that he could
19 not sit home and drink a beer
20 knowing that there were young
21 soldiers who needed a trauma surgeon
22 in Iraq. And he responded by
23 joining the U.S. Army Reserve
24 Medical Corps, and less than one

1 month into his second tour as a
2 combat surgeon, Major John Pryor
3 gave his own life in service to
4 others.

5 He leaves behind a wife, Dr.
6 Carmella Calvo, three children ages
7 four, eight and ten, his parents,
8 and his brother Richard, also a
9 local emergency physician.

10 And while saddened and
11 heartbroken at the loss of such a
12 young brother, colleague and friend,
13 we are also, I believe, very proud,
14 proud of the upbringing that each of
15 us in this room is responsible for
16 giving this loving father, this
17 dedicated husband, this skilled
18 surgeon, gentlemanly teacher, and
19 true American hero.

20 While incomprehensible to many
21 people, I think those of us here
22 today know exactly what John Pryor
23 was doing in Iraq and why he went
24 there.

1 John Pryor, as a soldier, we
2 salute you. As a physician and
3 surgeon, we seek to emulate you. As
4 a human being, we honor your memory
5 and we rededicate our own lives in
6 the spirit of service that you have
7 taught us.

8 May you rest in peace and may
9 God watch over your loved ones.

10 MR. FAETH: Thank you, Dr.
11 McEvoy. Thank you, Ed Wronski. If
12 everyone would, could you please
13 stand for a moment of silence?

14 (Whereupon, a moment of
15 silence was observed.)

16 MR. FAETH: Thank you.
17 For the record, I believe we've just
18 been joined by Dr. Cooper.

19 Moving on. Correspondences.
20 We did not make any. I did not
21 receive any at this time.

22 So I'll move to the chairman's
23 report. First and foremost, I want
24 to apologize for not being available

1 for committee meetings yesterday. I
2 had prior plans that I was unable to
3 cancel but I was able to alter a
4 little to be here. So I hope that
5 didn't inconvenience anyone. I hope
6 everyone had a good holiday season
7 and I hope your new year is kicking
8 off to a good start.

9 I want to thank all of you for
10 placing the confidence in me to
11 chair this prestigious committee. I
12 am both humbled and honored to do
13 so. I just hope that I can carry
14 the ball from Dr. Funk. I know you
15 don't have big feet, figuratively.

16 I look around and I know that
17 I'm not the -- I'm not the smartest
18 guy in the room. I'm going to be
19 looking to each and every one of you
20 for your experience and expertise
21 with the different aspects of the
22 healthcare system that we're going
23 to be dealing with. And I'm just
24 kind of here as more of a figurehead

1 to guide things, but all of you are
2 doing the work each and every day
3 and I greatly appreciate that. I
4 look forward to working with each
5 and every one of you and I think
6 we'll have a good year, hopefully a
7 very productive year.

8 I am sometimes a little
9 opinionated about things. I know
10 that, and I voice my concerns on
11 different issues. But at the same
12 time, I don't think I'm unreasonable
13 and I understand a lot of the issues
14 that have been going on with federal
15 mandates and whatnot. But we have
16 to -- we really have to look at the
17 bigger picture sometimes.

18 And if I could ask one thing
19 of the body, and I know it might be
20 difficult for some, when we do our
21 work here, it is for the public
22 interest. The public interest
23 supercedes any self-interest. And
24 it is very important that when we

1 have discussions -- I want your
2 perspective from your particular
3 region, your particular agency, but
4 that -- the overall good for the
5 public is really what this committee
6 is all about. So if people can take
7 their hat off that they have in the
8 private sector when they're -- from
9 their primary job and lay that
10 aside, take your knowledge and
11 expertise and bring that to the
12 table, that's where I want to go
13 with this committee. I'm hoping we
14 can all move forward and not allow
15 any conflicts to occur moving down
16 that road.

17 We know that the system itself
18 has issues. There are many issues
19 that are going on, recruitment and
20 retention obviously being a huge
21 one. There are many operational
22 concerns.

23 We know that the current
24 vetting situation is a problem. We

1 also know that there's a diversity
2 issue that hopefully we're going to
3 move forward with, especially with
4 the help of second vice chair, Mr.
5 Tim Czapranski, who was appointed as
6 the diversity chair. He is looking
7 for a committee to be formed and
8 people interested should see him.
9 We are looking, I believe, for six
10 to eight members, if possible.

11 And there's many things that
12 have been left open, and I'd like to
13 see, hopefully, some conclusions to
14 them or at least some progressive
15 work going towards it. I think that
16 the system itself overall, although
17 it functions, and it kind of
18 functions in spite of problems. And
19 that's quite often due to the hard
20 work of you members, the people that
21 you work with, you yourselves.

22 And we can't just keep the
23 status quo. I think -- I think we
24 need to look at ways of maybe

1 changing what we do and how we do
2 it. We need to be progressive. We
3 shouldn't be afraid to go those
4 venues.

5 People that know me know that
6 I'm looking at raising the bar. I
7 get a little frustrated when I hear
8 discussions -- though I can fully
9 understand concerns with like wave
10 form capnography being an overnight
11 issue for some and there's costs
12 associated with that and I agree.
13 There needs to be time to implement
14 things of that nature.

15 But on the flip side of that,
16 when I hear a discussion about how
17 some ambulances don't have
18 defibrillators on them, I'm sorry,
19 that's totally unacceptable. This
20 day and age, where defibrillators
21 have been available for fifteen,
22 twenty years, not acceptable. I
23 can't -- I can't understand any line
24 of thinking that would argue for

1 that.

2 So you know where I stand.
3 I'm hoping that we can all move
4 together as a group, as a team, and
5 that we have a very productive year.
6 Thank you.

7 That concludes my chairman's
8 report and I move to second -- first
9 vice chair, I'm sorry.

10 MR. DELAGI: Thank you,
11 Mr. Chair. I just have two brief
12 items to tend to today.

13 The first, it was my pleasure
14 to represent Mr. Faeth and the state
15 EMS council and join with Mr.
16 Wronski in presenting the state of
17 the EMS in New York State at the
18 FASNY EMS committee conference held
19 in my home region, Suffolk County,
20 on February 7th. The feedback that
21 I got from that was very, very
22 positive and folks genuinely enjoyed
23 the interaction that they had with
24 us and all walked away with a very

1 good experience.

2 Second item. Over the break,
3 since our last meeting, we worked to
4 secure a seat on the newly created
5 national fire protection association
6 technical committee that was
7 convened to go over suggestions for
8 revised ambulance construction.
9 This was important for us in two
10 ways. The first one is it certainly
11 follows our culture of safety
12 initiative. And secondly and
13 perhaps equally as important, is
14 that it allows the New York SEMSCO
15 to influence national safety
16 initiatives on ambulance
17 construction going forward.

18 So we're pleased that we were
19 given that opportunity and I want to
20 thank Mike McEvoy for volunteering
21 to represent the New York SEMSCO on
22 the NFPA ambulance construction
23 technical committee. Thanks.

24 And that is all I have for

1 now.

2 MR. FAETH: Thank you,
3 Bob. Does the second vice chair
4 have a report?

5 MR. CZAPRANSKI: Just
6 briefly I'd like to thank the
7 Department for the change in
8 location and dates going forward.
9 That's all for my report.

10 MR. FAETH: Thank you,
11 Tim. I guess we'll move along to
12 the EMS staff report.

13 MR. WRONSKI: Thank you.
14 The change of location, just to
15 comment briefly, is probably more
16 due to the economy than anything
17 else. As all of you know, hotels
18 across the country are hurting for
19 guests and that includes this one.
20 There's not as many conferences and
21 as many groups and committees
22 meeting as often as they had been,
23 even here in the capital, and so
24 that affects space. So we had more

1 bids this year than we had in the
2 last - I don't know - seven or
3 eight, maybe more. And so we took
4 advantage of that. So I'm glad you
5 like the venue. I like it. I'm
6 sure it will work out over time.

7 Jumping right into the first
8 issue and that is the state budget.
9 The state budget, as everyone knows,
10 is a negotiating process and there
11 will be negotiations as to what the
12 final budget will look like. But
13 obviously, no matter what it looks
14 like, it won't be an extensive
15 budget, one which has a lot of
16 growth. It will be a survival
17 budget, a budget that attempts to
18 keep essential programs going but
19 also to drill into the budget
20 deficits. I don't think there's any
21 doubt of that and that's going to be
22 the case, probably for the next
23 couple of years.

24 I have been advised that at

1 this point, no one is suggesting any
2 cuts in the EMS budget. That is
3 stable at this time. In regard to
4 funds, though, that get distributed,
5 there'll be more rules. There'll be
6 more hurdles to jump over. When I
7 hold meetings, I'll have to make two
8 or three arguments why I'm holding a
9 meeting and where we're holding them
10 and how much it costs and can we do
11 it in a different way.

12 So as I mentioned at the end
13 of last year, there may not be
14 sub-committee meetings that meet
15 separate from this very often, or if
16 there are, they may be telephonic or
17 in other ways. And even that may be
18 an issue, depending on what the
19 sub-committees are, and I'll get
20 into that in a moment. But we'll
21 get our business done. We have four
22 meetings this year and we'll get our
23 business done.

24 I do want to make mention here

1 that at present, there is the
2 possibility that state funding for
3 optional programs and aid to
4 localities may not be supported, and
5 that's a negotiated item, as well.
6 How is that important to EMS? There
7 are county EMS programs who get some
8 funding out of this. It ranges
9 anywhere from as little as \$20,000 a
10 year to as much as almost a half
11 million. So -- but they're optional
12 programs. They're not mandated and
13 the county pays for most of those
14 programs but the state provides some
15 funding for them. And those
16 programs, as well as some other
17 optional programs, are potentially
18 going to be cut from the budget.
19 You should look at your system. You
20 should look at your county and how
21 critical that fund is or is not in
22 your county. It's not critical to
23 all counties but it is an important
24 piece of the budget in some

1 counties. And so you should - you
2 know - discuss that and let your
3 voice be heard if it's critical to
4 your county or to your region.

5 Membership. Yesterday during
6 the SEMAC meeting, I was called out
7 for a conversation and I was advised
8 and asked to tell the council, both
9 councils, that there has been
10 movement on membership and there's a
11 number of members who should be
12 receiving notice over the next
13 couple of weeks from the Governor's
14 office that they've been vetted. I
15 don't have any names. I don't know
16 how many this is. We did have some
17 movement previously on two of our
18 physician members of the SEMAC, but
19 I have been advised that there are
20 some others members who have been
21 waiting for voting rights that
22 should be cleared over the next two
23 to some weeks. So before the next
24 meeting, certainly, you'll have

1 heard that and we'll keep working on
2 that.

3 I did make mention last time
4 that we'd also made some progress on
5 finding appropriate candidates who
6 meet the Governor's diversity
7 request and that we examined that
8 and their applications are being
9 reviewed, just as yours are, and are
10 not approved as yet but I expect
11 they would be approved prior to the
12 next meeting.

13 I had a meeting in Albany
14 about three or four weeks ago to
15 discuss council's -- it was a
16 meeting in which representatives of
17 different bureaus who have council
18 responsibility. And there are over
19 a hundred councils that operate --
20 advisory councils that operate
21 within the Department of Health
22 itself. And about forty or more of
23 these are statutory; you're one of
24 the statutory councils.

1 There's a set of rules and
2 requirements and policies that guide
3 all councils, so there was a meeting
4 of about fifty of us, and there were
5 two separate days of meetings of
6 this to discuss those rules and
7 requirements.

8 One of the things that came
9 out was discussions, policy
10 discussions, by voting delegates of
11 council outside of this process,
12 outside of the full meeting and the
13 sub-committee meetings that are here
14 in Albany which are scheduled, which
15 are promoted and which the public
16 has an opportunity to sit in on or
17 listen in on.

18 And the legal advice at this
19 meeting was that you cannot have
20 policymaking discussions offline.
21 And what does that mean? Well, it
22 varies. It doesn't mean you can't
23 do work on items that the council
24 would like you to do work on. It

1 doesn't -- but if there is a policy
2 discussion and one of the reasons
3 for the sub-committee or the TAG or
4 the special group is to discuss
5 whether or not -- and I'll give you
6 the example I gave to the lawyer --
7 medical control. Should medical
8 control -- should our policy, which
9 currently says it should be from a
10 physician to a -- an EMS provider
11 directly and not an in-between
12 person. That's a policy decision.
13 It can not be discussed offline, as
14 it has been on an e-mail account
15 that the entire SEMAC is part of and
16 they can share information prior to
17 the meetings and have discussions.

18 And the lawyers advice was
19 that, No, we can't do that. You
20 could talk about the facts of the
21 situation. Here's how medical
22 control is, in fact, provided across
23 the state and share that types --
24 type of information. But to sway

1 one another's opinion outside of
2 this public setting is not
3 appropriate.

4 And so we need to examine each
5 time we have a work group or a
6 sub-committee meet, what would be
7 the, you know, the tenure of that
8 meeting. And if it's to actually
9 make a policy decision, that needs
10 to come up here. What the committee
11 can do is do the preparatory work or
12 the work even after the policy has
13 passed if it requires writing
14 something.

15 So there's still a lot we can
16 do offline, but we do need to be
17 careful what we do offline regarding
18 the creation of a policy and if it's
19 something that would require a vote
20 of this council to create.

21 I don't pretend to know all of
22 this. There were questions, a lot
23 of questions, raised about this at
24 yesterday's SEMAC meeting. And I am

1 going request some written guidance
2 from counsel. And then as questions
3 come up, we have their ear and
4 they'll be happy to provide us
5 advice.

6 So it's not that we've done
7 anything illegal. That's not the
8 issue. The issue is that now we
9 have -- and this came out of, by the
10 way, a court case. And the court
11 case has driven all state agencies
12 to look at how councils operate
13 offline. And so this is the most
14 recent advice from our counsel's
15 office and we're going to have to
16 learn how to work with it. Any
17 questions on that? I may not have
18 any answers, though. Okay. Yes,
19 sir?

20 MR. BRANDT: Mr. Wronski,
21 do you know what the court case is
22 if we wanted to reference it?

23 MR. WRONSKI: I wasn't
24 given that. I don't even know if

1 it's a New York State court case,
2 but I do know that it was the
3 opinion of the two senior attorneys
4 for the Department in the room that
5 was the driving force for the
6 reevaluation. I'm presuming it was
7 a New York case on some council. It
8 wasn't ours. It was some other
9 council. I don't even know if it
10 was a Health Department council. It
11 could've been a Labor Department
12 council or whoever. Every state
13 agency has advisory groups.

14 MR. BRANDT: Thank you,
15 sir.

16 MR. WRONSKI: Okay. I
17 brought it to the attention of
18 everyone yesterday at the SEMAC
19 something that -- some people seem
20 to think only involves physicians
21 who work at these places, but it
22 involves you and New York City knows
23 this very well, as a matter of fact,
24 and that's hospitals.

1 I talked in the past about
2 hospital closures through the
3 Century 21 or Berger Commission
4 requirements, but there are also
5 hospitals that are financially
6 unstable and some of them may or may
7 not stay open over -- over time.

8 Two of them closed this last
9 weekend in New York City. Mary
10 Immaculate Hospital, which was also
11 a trauma center, and St. John's
12 Hospital filed for bankruptcy. They
13 could no longer stay afloat
14 financially and they closed and they
15 were both in the borough of Queens.

16 To this minute, we're dealing
17 with day-to-day issues that impact
18 EMS, because EMS, the City fire
19 department, has to respond to pickup
20 calls in this area and then bring
21 them to a hospital. But, there is
22 no hospital. There's nothing there.
23 So where do you go? You go to the
24 next hospital. And in Queens, that

1 happens to be a handful of hospitals
2 who were fairly busy before these
3 two hospitals closed.

4 So what's occurring and has
5 occurred over the last few weeks is
6 daily discussions, which I've been
7 involved in, as well, from an EMS
8 perspective, but daily discussions
9 with the hospital during their
10 closure plan on how to divest
11 themselves of their patients, how to
12 move them into other venues, who
13 hopefully can take over some of
14 their clinic work, etcetera, or even
15 purchase some of their outlying
16 urgent centers, etcetera, Their
17 methadone maintenance centers, their
18 other types of clinics, which
19 actually serve, on an annual basis,
20 hundreds of thousands of visits --
21 hundreds of thousands of visits, not
22 tens of thousands, not thousands if
23 you added them all up.

24 So there were, luckily, a

1 number of healthcare networks who
2 were willing to take over some of
3 these venues. And there were others
4 that could take their patients, but
5 this required an ongoing daily
6 conversation.

7 In fact, I was called out of
8 this meeting yesterday to answer
9 some questions on the phone about
10 that. And there is a conversation
11 going on right now with a group of
12 people regarding this. There is a
13 regular monitoring of how this is
14 working and it will work.

15 The City of New York is -- has
16 a strong healthcare system and it
17 will adjust to this and there will
18 be plans in the future to, you know,
19 upgrade healthcare services in
20 Queens. In fact, they're already
21 moving on those things.

22 But when you close two big
23 hospitals in one, you know,
24 geographic area, particularly in a

1 big city, you have an impact on EMS.
2 And Dr. Kaufman knows that very
3 closely and so does Dr. Cooper.

4 The -- there are others,
5 though. A. E. Lee Hospital is
6 filing or preparing a plan with the
7 Department to close, I believe, this
8 June. That's a very small hospital
9 and it serves a small community and
10 environment in upstate New York, but
11 it will have an impact and the EMS
12 system needs to adjust to it.

13 Again, the reason I'm bringing
14 this up is you need to stay awake in
15 your areas and understand which
16 hospitals are scheduled to close
17 because they are part of the Berger
18 Commission and they are working on
19 that to close. And I believe most
20 of the ones who needed to close or
21 were required to close have, in
22 fact, done so or have had
23 modifications made. But there are
24 others and you need to understand

1 the health of your particular system
2 and be prepared to adjust. And
3 hopefully that is something you can
4 do. Any questions?

5 MR. LEWIS: Just a quick
6 question, Mr. Wronski. When we
7 think about surge capacity and we
8 think about what's happening because
9 of the Berger Commission, has there
10 been a reassessment of our
11 capabilities to handle Pandemic flu
12 and other issues that could cause a
13 surge issue?

14 MR. WRONSKI: There is a
15 constant reassessment and certainly,
16 that question has come up before.
17 The -- but the bottom line
18 reassessment of what the Berger
19 Commission was attempting to do has
20 not changed, and that is that the
21 healthcare system as it exists is
22 not structured properly. And I
23 happen to agree with that. And I'm
24 not an expert, but I can see it and

1 I've been working closely with
2 healthcare issues for over twenty
3 years now and the system as it
4 currently exists needed to be
5 restructured.

6 The pure financial system -
7 all right - probably needs to be
8 restructured, too, and I don't have
9 the answers to that. There are
10 other people much more capable to
11 answer the financial issues. But
12 the healthcare system certainly
13 needs to be restructured and
14 remodeled to meet the needs of the
15 new century and new medicine.

16 And, you know, should
17 hospitals close? I'd like to see
18 them all stay open but I don't think
19 that's going to happen and part of
20 it's going to be driven by the
21 different medicine that's practiced
22 today. I think a large reason for
23 some hospitals closing has to do
24 with the appearance on the scene of

1 this different healthcare entity
2 called outpatient surgery centers,
3 the office space surgical centers
4 which -- and I've heard this, and I
5 apologize to those who can't respond
6 to me if they're on the other side
7 of this camera and some may have
8 different opinions.

9 But I heard from many, many
10 physicians that one of the big
11 changes in medicine has been where
12 many surgeries that happened in a
13 hospital and only required a one or
14 two day stay are now done in a
15 surgical center where you only stay
16 for a few hours, because the
17 techniques are so much better and
18 the ability to have a patient come
19 in, have a minor surgery. And some
20 of these minor surgeries don't sound
21 like minor surgeries to me, but they
22 apparently are. And they move out
23 that same day within hours.

24 The hospitals no longer

1 benefit from that in most cases, so
2 that's a change in your -- a real
3 change in your healthcare system and
4 where the money goes to. That's
5 also, in some cases, affected the
6 availability of specialists, who are
7 no longer as tied, in some areas, to
8 the hospital, because now they can
9 practice and provide surgery in
10 other settings. It gets very
11 complex. That's just one of the
12 reasons.

13 But I believe the system does
14 need to be restructured. A bad way
15 to restructure, though, is to see
16 two hospitals financially collapse
17 fairly quickly. That's not a good
18 way to restructure. A better way is
19 to plan it long-term and rebuild.

20 So I think you'll see more
21 commissions like the Berger
22 Commission, not necessarily
23 identifying who should close but how
24 to deal with the change in

1 healthcare structure. I just think
2 EMS gets hit on the head on every
3 one of these very quickly and that
4 you should stay in touch with your
5 system and, frankly, speak to your
6 local leadership, whoever that may
7 be, about the concerns for EMS and
8 how it will affect your system.

9 I've been asked in all of
10 these cases now, how will EMS
11 respond and how will they deal with
12 this? And I don't always know. I
13 have to reach out to you, frankly,
14 and ask. The City of New York, I
15 had regular conversations with Chief
16 Peruggia during this to understand
17 how this would all work and come
18 together. Yes, sir?

19 DR. KAUFMAN: I was just
20 going to say thank you for your
21 comments, and absolutely, I think
22 obviously at the fire department in
23 New York City, this has been a major
24 problem we've been facing over the

1 past few weeks.

2 The problem of these hospital
3 closings is also the fact that we're
4 losing their ambulance tours which
5 will be exacerbated by the fact that
6 the city, the 9-1-1 system, will be
7 losing additional hospital tours
8 anticipated this summer because of
9 other budget problems.

10 We are fortunate in New York
11 City that we have great redundancy
12 of ambulances, so we should be able
13 to, you know, deal with a lot of
14 these lack of tours. However, we
15 are trying to figure out ways to
16 deal with these problems,
17 considering all kinds of options
18 including alternative destinations,
19 delaying the response to possibly
20 the least emergent calls, really
21 focusing on what is the core mission
22 of really the 9-1-1 system in New
23 York City.

24 We've been having these

1 conversations, obviously, at the
2 fire department as well as the
3 REMAC, discussing altering possibly
4 the destinations we bring patients
5 to, all in the goal of trying to
6 maintain the EMS system in the city
7 over the next few months.

8 So I think there will be a lot
9 of changes and we'll see. And
10 hopefully we'll be stronger in the
11 end.

12 DR. COOPER: Mr. Wronski,
13 thank you for your complete report,
14 as always, and your thoughtful
15 consideration of some of the issues
16 that are driving the current
17 economic climate for healthcare. I
18 have two brief comments.

19 As the only surgeon here, I
20 think it should be noted that while
21 outpatient surgical centers, as you
22 indicate, have been at least one
23 significant factor in the economy of
24 healthcare, it must also be

1 remembered that the payers who pay
2 for surgical care are forcing much
3 outpatient surgery to be done in
4 outpatient surgical centers because
5 of the lower fees that they charge.

6 That, of course, leaves, as
7 you pointed out, the hospitals that
8 care for a less affluent patient
9 care mix in less than optimal
10 circumstances. However, it's not
11 necessarily always the surgeons who
12 are driving this issue but rather
13 the insurance system that is behind
14 everything that happens in
15 healthcare, it seems.

16 The second point I might make
17 and to reiterate a point very
18 briefly I made yesterday at SEMAC.
19 While many hospitals have the option
20 of admitting patients or declining
21 to do so, and while emergency
22 departments have the option to
23 dispose of patients -- I don't mean
24 "dispose of" in that sense, but make

1 dispositions -- but make
2 dispositions of patients after a
3 screening examination has been
4 performed, emergency medical
5 services have no such option. If
6 9-1-1 is called, EMS must respond,
7 must transport the patient, and is
8 not in a position to say "no" to
9 anybody, even if it involves
10 driving, you know, scores if not
11 hundreds of miles, on occasion, with
12 gas prices being what they were and
13 expected to go there again very
14 soon.

15 The point that I'm trying to
16 make is that EMS really is the
17 bottom line safety net, and many of
18 these hospital closings take place
19 without, in my judgment, significant
20 discussion about impact upon
21 emergency medical services. And
22 that's understandable. It's not
23 that anyone is ignoring the plight
24 of the emergency patient on purpose.

1 It's more that we still maintain
2 this relatively artificial division
3 between article 28 and article 30,
4 which allows article 28 folks to
5 think about hospitals, leaving us to
6 think about ambulances.

7 So again, as I said yesterday
8 at SEMAC, if there is some way that
9 the Department processes that call
10 for closure plans on the parts of
11 hospitals that are in bankruptcy can
12 take note of impact upon not simply
13 healthcare in a community but upon
14 emergency access to healthcare and
15 specifically emergency medical
16 services, that would be very good.

17 I think that the advice that
18 the SEMAC can provide and that this
19 council could provide with respect
20 to impact upon emergency medical
21 services might be invaluable. And
22 of course, our commissioner, Dr.
23 Daines, has clearly indicated,
24 publicly and privately on numerous

1 occasions, that he is deeply
2 concerned about the access of
3 patients to emergency care when
4 necessary. And it's my belief that
5 he might welcome the type of advice
6 that the SEMAC and SEMSCO could
7 provide with respect to impact of
8 hospital closings on emergency
9 medical services in the region and
10 that that advice could greatly aid
11 thinking in regard to the public's
12 health.

13 MR. WRONSKI: Thank you
14 and I'll take that under advisement
15 with the Department that that
16 offer's been made.

17 A couple of last things. Mr.
18 Delagi has mentioned the Long Island
19 conference, FASNY, that the two of
20 us spoke at. I'd just like to thank
21 all the providers that came out to
22 that at eight o'clock in the morning
23 to hear me and Mr. Delagi speak.
24 I'm presuming that's why they came

1 out. Maybe not.

2 But they were there at eight
3 a.m., 120 or more of them, and
4 actually Mr. Delagi and his staff
5 had taught a whole day the day
6 before -- Friday, I believe -- the
7 CMEs preconference days.

8 So thank you to the providers
9 who continue to come out. I just
10 want to mention one thing that was
11 brought up, actually, by Bob to the
12 audience, and it is something we
13 also have to look at in EMS. And he
14 said, Okay, who's here today and how
15 old are you? And we looked out at
16 the 120 or 25 people and there was
17 probably two tables of young people.
18 They were the ones that were
19 chatting and not paying attention.
20 I'm only kidding. I apologize,
21 'cause there's some great young EMTs
22 out there. I'll hear about this
23 later.

24 But probably a hundred or so

1 who were there that morning were
2 all, in my view, youngest might be
3 in the late 30s and oldest in 40s or
4 50s and some even approaching my
5 age. And, you know, Bob talked to
6 them and reminded them that the core
7 of our system so much so across the
8 state that we have to make extra
9 efforts to increase the tables of
10 the young EMTs.

11 And so I just put that out to
12 you. That's a constant battle and
13 something that you need to keep
14 working on and we have to figure out
15 ways to do that so that we have a
16 state EMS director and a state
17 council member who speak in Long
18 Island twenty years from now and
19 there's somebody sitting there,
20 because the people who were 40 or 50
21 or 60 are probably going to retire
22 at some point and may not be here
23 twenty years from now. So I thought
24 it was a good comment that Bob had

1 made and observation.

2 I mentioned yesterday air med
3 concerns. There still is a national
4 look at air medicine. We will
5 expect a report to come out of that
6 national committee. I want us to
7 pay close attention to that and not
8 forget our own issues in air med. I
9 think we're a state that's ahead of
10 many of the other states in having
11 looked at our system and our issues
12 and tried to provide guidance to the
13 air med system, but I think the
14 federal look at this will result in
15 two things. It will result in some
16 white paper that will come out and
17 talk about what needs to happen in
18 air medicine and it may result in
19 some change in federal legislation.
20 And I believe there's a lot of
21 support now to change some of the
22 legislation to give states more
23 authority in how air med is provided
24 in their state, because as you know,

1 at present, there is a federal
2 preemption to CONs for air medicine.
3 And so a helicopter system can
4 provide service in your state. It
5 does have to meet the requirements
6 for the medicine, but it doesn't
7 have to compete in the CON process
8 or, you know, be evaluated.

9 So, technically, you can have
10 more air services than you really
11 require in some given geographies of
12 your state. I don't think that's
13 the issue at the moment in New York
14 State, but it is in some states and
15 it is on the table out there. So
16 you may see some changes over the
17 next couple of years.

18 Just to remind everybody that
19 May 21st is the EMS memorial service
20 here in Albany. There will be two
21 providers who will be added to that
22 memorial. Mark Davis, while he'll
23 certainly be mentioned, he'll be
24 added next year to the memorial

1 service, but there are two other
2 providers who died in the line of
3 duty whose names will be included on
4 the memorial.

5 That's it for my report unless
6 there's questions.

7 MR. LAMARCA: Just one
8 question, and this, perhaps in
9 certain areas, may relate to
10 hospital closings or downsizings.
11 But I know we frequently hear the
12 issue of hospital diversions and,
13 again, the Department's been active
14 in trying to, I guess, work with
15 facilities to make sure that is
16 minimized. And it's up to some
17 local facilities. I mean, they now
18 state that we no longer divert.
19 That sounds good. However, when we
20 have three paramedic units in a
21 small city sitting in that ER
22 because there are no beds and
23 they're saying they don't divert and
24 their remedy is just to keep them on

1 the ambulance stretchers so that,
2 you know, when they find time or
3 find a bed, they'll open it up. And
4 having emergency calls still coming
5 in where we actually have to almost
6 go to mutual aid to bring in more
7 units while three of them sit there
8 within half a mile of the call is
9 just getting ridiculous.

10 So I don't know if the
11 Department can do anything about
12 that or clarify this issue, but not
13 being on diversion, I understand
14 that. Making that statement, I
15 understand that. But actually
16 meaning that we'll just keep you on
17 the stretcher until such time that
18 we find a hole to put you in is just
19 having an adverse effect in many
20 areas.

21 MR. WRONSKI: I've
22 actually had a couple of formal
23 letters come to me. I've previously
24 responded to one of them. I've been

1 asked to try to update that and
2 maybe issue a policy guidance on
3 what EMS crews do when they show up
4 at a hospital and they're kept
5 there. What do you do? Can you
6 leave? It's a touchy gray area and
7 it's a case-by-case issue.

8 I did say in my letter of
9 response to one physician a few
10 months ago that EMS crews are not
11 obligated once they have turned over
12 the patient to the triage nurse.
13 Here I am and I have this patient
14 and here's what the problem is as we
15 see it and now that patient is
16 yours. The patient is at your
17 hospital and you have to take that
18 patient. Technically, the EMS crew
19 would be within its rights to leave.

20 Do you take your patient off
21 and lay them down on the floor? No,
22 you don't do that. Do you insist on
23 getting a hospital stretcher? Yes.
24 And you keep -- you keep putting

1 that in the nurse's ear so they hear
2 it and they, eventually, are really
3 more annoyed at you being there than
4 all these patients. And things will
5 happen.

6 At the same time, I ask you to
7 have absolutely some patience. You
8 know, when you walk into an ED and
9 you see the staff absolutely
10 overwhelmed, I ask that you work
11 with them on this and use your
12 judgment. But again, you know,
13 you're not required to stay there
14 for any excessive amount of time and
15 hold up your healthcare delivery
16 network, which is your ambulance,
17 from the system. And hospitals need
18 to know that too and work with you
19 on freeing up your ambulances.

20 I did promise that I would try
21 to work on a more comprehensive
22 guidance document. I have a draft
23 and I will try to have something out
24 before the next meeting. But,

1 again, it's not going to be "here's
2 an absolute" because this isn't an
3 absolute situation. It really is
4 fluid and a lot of it's your
5 judgment.

6 I will discuss this with
7 others in the Department again, that
8 this is a concern that keeps coming
9 up. I'll tell you now that there is
10 an ED -- actually a hospital
11 overcrowding committee that Dr.
12 Henry sits on that is put together
13 by the Department and has a variety
14 of interested parties, including the
15 hospital associations in the city
16 and the state.

17 And the Department's made a
18 decision to take it to the next
19 step. They'll be notifying
20 hospitals soon of the process by
21 which the Department will be making
22 some unannounced visits to emergency
23 departments to evaluate them, both
24 to learn how emergency departments

1 and hospitals are dealing with
2 overcrowding, hopefully come away
3 with some best practices, hopefully
4 identify the worst cases and see if
5 we can assist in correcting them.

6 But there is a plan to do that
7 and it will happen during the course
8 of this year. That may hopefully
9 have an impact on this. I
10 personally think it will take more
11 and a little bit additional work
12 over time. But that is the next
13 step that's planned. So your issue
14 isn't -- we're not blind to it, but
15 I don't have an immediate solution
16 for you.

17 What I would ask is if your
18 system is really impacted -- I mean,
19 you're feeling it -- either you as a
20 provider of care or your region send
21 me a letter directly on that or give
22 me a call that day. If you can't
23 get out of the ED, you know, give me
24 a call. I'm willing to take that

1 call and see what I can do and talk
2 to our regional offices and see if
3 we can talk to the hospital and
4 affect something, you know, if you
5 can't get changes. But certainly on
6 a regular ongoing, systemic basis,
7 let us from the regions help. It's
8 more information for the Department
9 to look at and consider and really
10 underline the urgency of the issue.

11 DR. COOPER: Mr. Wronski,
12 it strikes me hearing all these
13 stories this morning. We've all
14 known for some time that emergency
15 medicine is broadly defined to
16 include all emergency healthcare,
17 including trauma surgery. It's
18 really the canary in the coal mine
19 with respect to the rest of the
20 healthcare system.

21 What's clear is that EMS is
22 the perhaps, literally,
23 figuratively, the wings on that
24 canary. And while we're going to

1 first in the hospital world see all
2 the problems that arise as a result
3 of the deterioration of the economic
4 basis of the healthcare system in
5 the emergency department, we're
6 going to see even earlier indicators
7 in the world of emergency medical
8 services in terms of diversion,
9 increased turnover time, etcetera,
10 etcetera.

11 And to the extent that it's
12 feasible for us, as its official
13 advisors, to inform the Department
14 and the Commissioner that this --
15 that emergency medical services are
16 the wings on that canary and to
17 follow our situation very, very
18 closely for potential harbingers or
19 problems down the road, I think that
20 would be a very useful thing. I'm
21 not quite sure how we can bring this
22 to their attention but I know you
23 have your ways, Mr. Wronski, and
24 trust that you will do so.

1 MR. WRONSKI: Thank you.

2 Any other questions?

3 MS. ELLIS: I just want to
4 make a comment on both of the
5 hospital EMS-related issues. It's
6 obviously a statewide issue and as
7 Ed said, the ED overcrowding
8 advisory group is working on a
9 statewide look at the problems.
10 They can't suggest enough that
11 locally in your regions how
12 important it is for EMS to
13 collaborate with your hospital
14 people.

15 And surge capacity, ER
16 overcrowding, they're one in the
17 same. And many in -- all hospitals
18 in New York State are required with
19 deliverables in our preparedness
20 programs to collaborate with your
21 local health department and your
22 prehospital people.

23 So if you're not at the table
24 with your hospital people, then

1 you've got to find out who the key
2 players are, 'cause they might not
3 be people that you're used to
4 working with. Some emergency
5 preparedness people could be someone
6 in infection control that you've
7 never met or something and they're
8 really leading the team at a
9 facility with numerous players,
10 local health departments, hospitals
11 and EMS needs to be there because
12 you're an integral part. So if you
13 really haven't, I would suggest
14 highly that you investigate at your
15 local level.

16 MR. FAETH: Thank you,
17 Phyllis. Any other questions or
18 comments? Mr. Lewis.

19 MR. LEWIS: A comment.
20 Without question, we know that
21 partnering with community hospitals
22 is very important to all of us. We
23 have to work as a team and we always
24 do work as a team and I think it's

1 very difficult for us to be
2 reporting hospitals for not
3 processing patients. It isn't in
4 our best interest to be doing that.

5 So I'm encouraged by what
6 you're saying that site visits will
7 help us solve those problems versus
8 creating an adversarial role with
9 hospitals. We really don't want to
10 do that. We want to work as a team.
11 We take these trauma patients in and
12 we stay with those patients and help
13 as much as we can every day of every
14 week. And I'm encouraged.

15 Can you give us a timeline of
16 when a letter would go out and when
17 you may start visiting to better
18 understand what's happening out in
19 the field?

20 MR. WRONSKI: Both Phyllis
21 and Dr. Henry are on that
22 committee. I don't think -- remind
23 me. Was an actual date --

24 MS. ELLIS: Dr. Morley

1 said the letters were approved and
2 would probably go out by the end of
3 this month. I don't know what the
4 timeline for surveys would be and
5 how often.

6 MR. LEWIS: I think it's
7 very encouraging what you're doing
8 and I applaud you and I can't wait
9 to see these site visits so you can
10 watch what's actually occurring,
11 especially in our larger urban
12 areas. Thank you.

13 MS. ELLIS: I think one
14 other thing on the survey process.
15 It was important to note that when
16 we think of surveys in the facility
17 end, we think of punitive-type
18 surveys.

19 And the discussion was
20 identification, obviously, of things
21 that are not occurring that should,
22 but best practices and how the rest
23 of the facilities impact the ERs.
24 Because it's not just the emergency

1 departments getting those patients
2 to inpatient beds and surgical
3 schedules. So it's more of an
4 overview of what's happening and
5 where it's happening and where can
6 we spread that word around the
7 state.

8 MR. FAETH: Any other
9 comments? All right. Thank you,
10 Mr. Wronski. We move the agenda to
11 Dr. Henry for state EMS medical
12 advisors.

13 DR. HENRY: Let me start
14 with talking about the crowding.
15 You know, it's -- I was at that
16 meeting and my personal
17 recommendations are that people
18 include diversion and the time it
19 takes to get seen in the emergency
20 department on a dashboard that gets
21 published and then gets promulgated
22 on the internet, just like your time
23 to antibiotics for pneumonia or
24 whether you get aspirin if you have

1 a heart attack.

2 One rationale is that there is
3 a paper out now by Linda Green from
4 Columbia University that looked at
5 diversion in New York City and
6 correlated it with deaths from acute
7 myocardial infarction. And when
8 there was high rates of diversion,
9 the deaths from acute myocardial
10 infarction increased. Now, that has
11 face value.

12 If you look at papers, it
13 doesn't matter what country they're
14 in, people with acute myocardial
15 infarction who arrive by ambulance
16 are a sicker population than those
17 that are driven to a hospital. So
18 if there's delays in getting people
19 to a ER or to a hospital or for
20 treatment when you have a bad MI,
21 that has face value to me that the
22 death rates would go up.

23 That being the case, I think
24 it qualifies as much as antibiotics

1 for pneumonia on whether it should
2 be a measurable dashboard and
3 perhaps payments should be tied to
4 timeliness of care for sick people.

5 Another recommendation I have
6 is that people define in their area
7 what diversion means. There was a
8 state law, I think it might have
9 been taken off the books from '83.
10 But in New York City, the '83 law
11 defined diversion of critical
12 patients as when incoming patients'
13 life would be in danger or someone
14 already in the hospital's life would
15 be in danger.

16 Given Linda Green's paper,
17 that sounds like that was the case.
18 That's a pretty serious situation
19 when you're in a state and a
20 community where people's lives are
21 in danger. So certainly diversion
22 should be measured and reported. We
23 currently don't tabulate that in New
24 York and I think we should, 'cause

1 you can't manage what you don't
2 measure.

3 So regions certainly could
4 accumulate this information.
5 Regions could ask what it means to
6 be at the request of going to
7 diversion for ambulances. What, in
8 fact, are you telling us? Why is
9 this happening? And I think, also,
10 regions have the ability to measure
11 and aggregate and promulgate times
12 that it takes in the hospital from
13 arrival until they're ready to leave
14 again. And that's a measure and
15 there's no judgment on that, per se.
16 It's just a number. And that's
17 within our ability to measure and
18 that could be a proxy of crowding or
19 what happens, a commitment to time.
20 But I think people have to take
21 action. Otherwise, it's not going
22 to change.

23 I think given the climate
24 we're in, I think things are going

1 to get tougher. I think we're going
2 to see more people who lose their
3 jobs and don't have insurance. I
4 don't think the economic situation
5 for hospitals or healthcare is going
6 to improve in the future. It's
7 really a measure of how we pull
8 together to take care of each other.
9 We'll all be asked to do more with
10 less, and we should probably get
11 prepared for that and keep giving
12 good care to people and not blame a
13 situation that's affecting everyone
14 in many countries for our ability to
15 respond.

16 So I think it's time for some
17 action on the region's part and I
18 think people would welcome that. I
19 know that -- I don't know if you
20 want to talk about it, Dr. Kaufman,
21 but there were demonstration
22 projects in the city on redirect,
23 right, that had a profound effect on
24 some of the hospitals. I don't know

1 if you'd comment on that now, but
2 there's something that people in
3 other regions might want to do.

4 DR. KAUFMAN: Certainly,
5 these issues have been identified
6 for years of ambulances having
7 delayed turnaround times. In New
8 York City, we actually report to
9 every hospital its turnaround time.
10 On a monthly basis, the hospital
11 receives a report for that hospital
12 for all the ambulances that went to
13 that hospital.

14 In order to reduce turnaround
15 times, we started a redirection
16 program which, basically, required a
17 forced diversion for those hospitals
18 that had more than three ambulances
19 at their facility for more than
20 thirty minutes. And as soon as they
21 released one of those ambulances,
22 the hospital would go off
23 redirection.

24 The theory being -- I mean, in

1 essence, it's a strange concept
2 because here we're constantly
3 working to prevent hospitals from
4 going on diversion so we can bring
5 our patients to that closest
6 appropriate hospital and quickly
7 turn around the ambulance. So in
8 this case, where a hospital is put
9 on redirection, the ambulance would
10 go to the next closest hospital,
11 which would be a longer transport
12 time. However, we found that it
13 actually did reduce the entire time
14 the hospital was on the scene and
15 really stuck at that ambulance's
16 emergency department.

17 What we found as we went and
18 visited the hospitals to discuss the
19 program was many of the hospitals
20 actually put plans in place. They
21 were very concerned about being put
22 on redirection. They did not want
23 to be put on redirection, which
24 comes back to what a lot of you were

1 saying about meeting with the
2 hospital leadership, discussing this
3 plan. And that hospital leadership
4 is often different than the
5 emergency department leadership in
6 many ways, who are trying to build
7 the situation. But when you sit
8 with the CEO of the hospital and
9 explain to them that these patients
10 will be going to a different
11 hospital, many had put plans in
12 place where, when the situation
13 arose and they were informed they
14 were put on redirection, some even
15 had an emergency brought in where
16 the nursing director or some
17 executive would respond to the
18 emergency department, extra staff
19 would respond, often an extra nurse
20 would be immediately assigned to
21 triage to triage those units that
22 were waiting to quickly get them out
23 of the emergency department.

24 So that has been a success so

1 far. I'd say that there are some
2 issues with -- we certainly heard
3 complaints from the hospitals that
4 turnaround time does seem like a
5 clearcut time, although as
6 everything, it may not be.

7 So, for instance, sometimes
8 the hospitals would say, Well, that
9 ambulance is sitting in our bay.
10 You know. They haven't pressed
11 their "available" button yet, but
12 that's not our fault. Or, The
13 ambulance crew is in the bathroom or
14 getting coffee. So I think there
15 are all those issues that come up.
16 But overall I think this redirection
17 plan has been a success.

18 And just to comment on one
19 other point, because there actually
20 was a paper put out -- I was one of
21 the co-authors -- looking at a lot
22 of the mechanisms for handling
23 extended turnaround times. There
24 was actually -- not in New York, but

1 one region in the country where they
2 actually stocked extra ambulance
3 stretchers in the emergency
4 department to be able to put the
5 crew back in service and leave the
6 patient on the ambulance stretcher
7 in the emergency department.

8 So this is not where,
9 obviously, we'd want to go, but
10 certainly I think this is a problem
11 that is being dealt with around the
12 country, as you suggest.

13 MR. LEWIS: Could you
14 maybe share with us what your
15 turnaround times are currently in
16 the city with your crews to get them
17 back on the street?

18 DR. KAUFMAN: Sure. On
19 average -- and it certainly varies
20 by hospital and borough -- on
21 average, I think turnaround times
22 are between twenty-five and thirty
23 minutes.

24 MR. LEWIS: That's a good

1 number.

2 MR. KAUFMAN: From the
3 time the ambulance arrives in the
4 ambulance bay until the time they're
5 available.

6 MR. LEWIS: That's great.

7 DR. HENRY: Thanks.

8 That's an example of taking action
9 in a similar problem.

10 Moving to another couple
11 items. I met with Mr. Wronski and
12 some of his staff and we talked
13 about the work that should be done
14 by our disaster group, together with
15 the STAC, and we're planning a
16 meeting probably in concert with our
17 next meeting, as well as the ED
18 standards group.

19 And because of staffing
20 availability and travel for many of
21 the members, we'll probably try to
22 do that in concert with our next
23 meeting, as well. So, those
24 meetings will continue.

1 The last item I'd like to talk
2 about is the publication from the
3 CDC in the morbidity and mortality
4 weekly report, their weekly report
5 that, I think, was sent to everyone
6 on the field triage of injured
7 patient's guide.

8 People are familiar with this
9 because we used the product when we
10 redid our New York State trauma
11 triage guidelines many months back.
12 The only difference was, in ours, we
13 maintained PULSE criteria. That's
14 really the main difference between
15 the CDCs.

16 If you recall, we asked
17 regions to meet with their regional
18 trauma groups to talk about patients
19 who had physiologic or anatomic
20 criteria when the direction was to
21 go to the highest level trauma
22 center available, what that meant on
23 a regional basis. So that exists.

24 So there's a lot of

1 explanatory text that may or may not
2 be helpful, but Dr. Rick Hunt, who
3 was in Syracuse for a number of
4 years and now heads the division of
5 injury at the CDC, he asked me to
6 make it widely known to us in New
7 York State that this document, if
8 read and questions are answered at
9 the end, will give free CME credit
10 to physicians, nurses and EMS
11 personnel.

12 And the website for those at
13 home, if you want it, is
14 www.cdc.gov/fieldtriage. And you
15 can get the document online there,
16 as well as through cdc.gov/mmwr. So
17 that's available.

18 Now, as a -- I got a special
19 ability here to offer everyone in
20 the room two hours of CME. We're
21 going to have a group Q & A here.
22 And Al, you have the first question.
23 The physiologic criteria that
24 mandate transport -- Let's see. Who

1 wants the second question, just to
2 be fair? Colleen, you can have
3 fourteen here.

4 I'm kidding, but it is
5 available and it's a good way to
6 refresh our own personnel on
7 guidelines that are -- New York
8 State's really similar to the PULSE
9 criteria, so if you make that known
10 to your groups, I'm meeting Dr.
11 Hunt's request to spread the
12 document.

13 All right. That's my report
14 and I can do the medical standards,
15 if you'd like, later.

16 MR. FAETH: Did you have a
17 question, Dr. Funk?

18 DR. FUNK: Just a quick
19 comment on that document. I
20 appreciate it being sent out so that
21 we could all review it. It was
22 interesting reading. There is a lot
23 of data from New York State's trauma
24 registry that is quoted in it and

1 from papers that have come out of
2 that registry.

3 Wondering -- I know that we've
4 looked at this question before when
5 we started to look at the helicopter
6 triage of trauma patients and the
7 triage of patients to level one
8 versus level two trauma centers.

9 We haven't, in the past,
10 differentiated in New York State
11 between level one and level two
12 trauma centers in many circumstances
13 and it's not relevant in many
14 regions because there is only one
15 trauma center, if a trauma center at
16 all.

17 But we've asked the question,
18 if you're in a helicopter and you
19 could go one direction or another
20 direction, and one direction is a
21 level two and one direction's a
22 level one, this data seems to
23 indicate that there are certain
24 physiological criteria that would

1 say you should go to a level one
2 over a level two, even if it means
3 traveling a little bit further.
4 Have we, or do we want to consider,
5 revisiting that?

6 MR. WRONSKI: We can, but
7 what I would like to do is before we
8 jump to that, because I think -- I
9 think it really varies depending on
10 who your trauma center is. And it's
11 also a question, you know, can we
12 adequately identify that patient who
13 would be better served at a regional
14 center? And there definitely are.

15 This is no negative comment on
16 a level two center. A level two
17 center is supposed to be a fully
18 capable hospital, surgically, to
19 deal with trauma. But as everyone
20 knows, a regional center, a level
21 one, is typically better staffed or
22 staffed deeper by more specialists.
23 And on occasion, a level two will
24 transport patients to a level one.

1 Can EMS do that on its own is a
2 question and can we adequately
3 identify what those patients or who
4 those patients are in this state?

5 We can pose that question to
6 our State Trauma Advisory Committee
7 and ask the School of Public Health
8 to attempt to take a look at the
9 data and see if it's possible to
10 pull that out. What I find every
11 time I ask them about -- ask those
12 kinds of questions, it becomes more
13 and more difficult sometimes for the
14 data to answer that question in a
15 scientific way, but we can certainly
16 ask.

17 DR. HENRY: Well, the
18 paper that pushed -- you know, our
19 paper in New York that supports that
20 is based on '96 to '98 data, and
21 that one showed a significant change
22 in outcome for patients with
23 physiologic criteria that went to
24 level one centers versus level two

1 or community hospitals. Okay.

2 It's tough to repeat that
3 because it takes big numbers and
4 recently -- there is only three
5 regions in the state that have
6 community hospitals in their trauma
7 registry, but three regions are able
8 to do it. So that study hasn't been
9 repeated, but that does exist. It
10 has face value, too.

11 So that's a decision that was
12 really left to the regions to
13 discuss, and it's hard to get the
14 data to support that on a regional
15 basis because the numbers get
16 smaller. And thankfully, you know,
17 the deaths are finite, they're not
18 infinite, they're not huge numbers.

19 I'll say something else about
20 this. Dr. Marx met with someone at
21 the Health Department, because we've
22 all been pushing to keep the trauma
23 registry robust and
24 population-based.

1 That's the reason New York's
2 data was so important to the CDC,
3 because we have a lot of people in
4 New York and when we had a rich
5 database, it was a value to people.
6 It makes cost-effective decisions
7 and it helps save lives.

8 You know that nationally, the
9 papers show in the New England
10 Journal by McKenzie, sponsored by
11 the CDC, that if you went to a
12 trauma center, your chance of dying
13 was twenty percent less, and
14 twenty-five percent less at thirty
15 days. So that's a huge difference
16 in healthcare.

17 They say, well, can you
18 demonstrate that in New York State?
19 It's harder to do that in New York
20 State because we take people -- we
21 have a trauma system now. You don't
22 stay in the community hospitals.

23 And the way we do risk
24 adjusted analysis, it doesn't show a

1 twenty percent difference in outcome
2 because we've distributed patients
3 to trauma centers or people are
4 transferred. So you couldn't repeat
5 that experiment unless you wanted to
6 stop the trauma system to take
7 severely injured patients to
8 community hospitals and show what
9 the death rate was.

10 So it's hard to show those
11 numbers that would get public
12 attention or economic commitment,
13 but I believe they're true and you
14 have to sort of use proxy to make
15 judgments.

16 MR. FAETH: Dr. Cooper?

17 DR. COOPER: I just want
18 to underscore that last point that
19 Dr. Henry has made. It's vitally
20 important that people understand the
21 risk adjusted mortality rate
22 statistic.

23 Your system is performing
24 optimally and sick trauma patients

1 are doing better in regional centers
2 when the risk adjusted mortality
3 rates are identical across the
4 system.

5 Intuitively, one would think
6 that because the risk adjusted
7 mortality rate ought to be lower in
8 a regional trauma center, but that's
9 not the way the statistic works.
10 The statistic works by looking at
11 the mortality rate that one would
12 expect across an entire system.

13 So when sicker patients in a
14 regional trauma center have the same
15 risk adjusted mortality rate as less
16 sick patients in community
17 hospitals, that means the regional
18 trauma centers are, in fact, doing
19 better and doing their job.
20 Understanding that is vital to
21 policymakers, because without that
22 understanding, one looks at raw data
23 and says, There's no benefit to
24 being in a trauma center, when, in

1 fact, the statistic is demonstrating
2 absolutely, unequivocally, that
3 there is.

4 MR. FAETH: Thank you, Dr.
5 Cooper. Any other questions,
6 concerns? Mr. Delagi.

7 MR. DELAGI: Just one,
8 just to expand on the comments as it
9 relates to ambulance work.

10 When you get a helicopter,
11 it's a little bit easier to
12 differentiate between a level one
13 and a level two because in most
14 cases you're also getting a provider
15 with more sophisticated training in
16 a level of care. But when you're
17 talking about a BLS ambulance
18 bypassing a level two trauma center
19 for a level one trauma center in the
20 face of all of this good data that
21 suggests there is a better outcome,
22 the question has to be asked how
23 much of the golden hour does the
24 trauma community want us to take,

1 driving past one trauma center to
2 get to another.

3 And I realize that's probably
4 a local question that needs to be
5 asked, but I think it would be
6 worthy of some discussion, at least
7 at the state level, as we start to
8 consider changing our policy to
9 preferentially take patients to a
10 level one.

11 MR. FAETH: If I might
12 even comment on that. Right now
13 there's an operation in play in New
14 York City with regard to the STEMI
15 centers and maybe we can implement
16 that where the crew gets in touch
17 with medical control on vital signs,
18 condition, and actual presentation
19 of your patient. Maybe the medical
20 director of that region can make a
21 suggestion or give permission to
22 bypass those hospitals. Dr.
23 McEvoy?

24 DR. MCEVOY: I've looked

1 at that decision scheme and I was
2 actually at AMSP when they rolled it
3 out and I think that it's very
4 clearcut and there may well be some
5 conflicts on what's in this trauma
6 triage decision scheme and what our
7 air medical triage guidelines are
8 right now in New York State.

9 So I would sort of encourage
10 Dr. Funk to take a look at that and
11 just see if there are conflicts
12 between those two, what are those
13 conflicts, and maybe we do have to
14 make a modification in where we're
15 taking people. Because it
16 specifically has criteria to go to a
17 level two versus a level one, and
18 I'm not so sure that's consistent
19 with what we're doing right now.

20 MR. FAETH: Dr. Funk?

21 DR. FUNK: They are not
22 consistent, simply because in New
23 York State we have not
24 differentiated. And we're talking

1 about making these decisions on a
2 regional basis, but this is a
3 problem that crosses regional lines.

4 There's, you know, at least in
5 upstate New York, very rarely more
6 than one trauma center in a region
7 'cause there doesn't need to be. So
8 there's a level two in this region
9 and a level one in this region. And
10 currently we go to the closest
11 appropriate hospital and that is --
12 there is no differentiation between
13 level one and level two, whereas
14 other decision schemes do identify
15 that there is a subsection of
16 patients that are -- that would do
17 better at a level one. And while in
18 a ground ambulance, you go to the
19 closest appropriate hospital, and in
20 most cases, that's simply the
21 closest trauma center, whether it's
22 level one or level two. And a
23 helicopter, because of the speed of
24 travel and the fact you don't have

1 to follow roads, you can get to a
2 level one in a shorter amount of
3 time and that might be the closest
4 appropriate hospital if we take this
5 into consideration.

6 So I think the question that
7 the air medical committee posed -- I
8 don't know, more than a year ago
9 probably before we embarked on our
10 three month study at the beginning
11 of last year, was should we take the
12 patients in a helicopter and take
13 them to level one centers if they're
14 trauma patients.

15 And the question was then
16 asked, Well, are they really sick?
17 Well, we asked that question, and in
18 fact, they are. And so now we have
19 to come back to that and say, Okay,
20 they're really sick. Now should
21 they go to level one trauma centers
22 if it's a reasonable decision to
23 make? It's a small number of
24 patients but we have all the New

1 York State trauma registry data,
2 albeit ten years old, but it's what
3 we have and we have papers like this
4 coming out and the NAEMSP criteria
5 and practice that we see in other
6 states suggesting that it would be
7 better for this small subsection of
8 patients to go primarily to a level
9 one trauma center if it's reasonable
10 to do that in terms of time and
11 travel and that sort of thing.

12 DR. MCEVOY: But you also
13 have a subset that could continue to
14 go to level twos?

15 DR. FUNK: Absolutely.
16 And every level two has different
17 services available and the teams in
18 those areas know what those level
19 twos are and what their services are
20 and I would never suggest that a
21 patient who could be appropriately
22 and expertly managed at a level two
23 should not go to that level two.

24 But there are that small

1 subsection of patients that have
2 been identified that should probably
3 go to a level one trauma center and
4 to allow the flight crews to make
5 those decisions or teams that have
6 that opportunity if they're faced
7 with two different trauma centers,
8 allow them to differentiate and make
9 that decision based on those
10 criteria.

11 MR. FAETH: Thank you, Dr.
12 Funk. Speaking for myself, if I'm
13 on the receiving end, I would like
14 to be taken to the most appropriate
15 facility for my particular
16 condition, given conditions that are
17 available.

18 MR. WRONSKI: If I could
19 just comment quick and kind of wrap
20 this up. What I'll do is formally
21 ask the State Trauma Advisory
22 Committee to comment on this piece,
23 as they have representatives from
24 all the trauma facilities at the

1 table, and to put this as an agenda
2 item for their discussion.

3 I'll also talk to the School
4 of Public Health because they are
5 preparing a state report that will
6 include four years of data ending
7 with 2006 data. It is a slightly
8 different data set, as Dr. Henry's
9 mentioned. It doesn't include
10 community hospitals, but it does
11 include all the trauma hospitals.

12 So I'll ask both the school to
13 work on, as part of their work on
14 the state report, to include some
15 look at this and also that the State
16 Trauma Advisory Committee put this
17 on their agenda for the next
18 meeting.

19 MR. FAETH: Thank you, Mr.
20 Wronski. Thank you, Dr. Henry, for
21 your report.

22 I don't see anybody nodding
23 off, but I do know that the hotel
24 wants you to check out before

1 eleven. So, I guess before we go
2 into committee reports, we're
3 approaching eleven quickly, I guess
4 we'll take a fifteen minute break.
5 Sounds good. Be back at 10:40 would
6 be good. Thank you.

7 (Whereupon, a recess was
8 taken.)

9 MR. FAETH: Okay. If
10 everybody could please grab a seat,
11 we're going to get started. Okay.
12 Thank you.

13 Before we move into committee
14 reports, I believe Valerie has
15 something she wants to say to
16 everyone.

17 MS. OZGA: First of all,
18 my apologies. I got a little
19 confused about the September dates.
20 I had said on the record earlier
21 that the dates were moved to the 8th
22 and the 9th. That is incorrect.
23 They were the first dates we had
24 chose, but because that is Labor Day

1 weekend, we actually moved the dates
2 to September 2nd and the 3rd. I
3 have checked with the hotel and that
4 is official. So my apologies to
5 anybody who wrote in pen in their
6 date books, but it is September 2nd
7 and 3rd, it is a Wednesday and a
8 Thursday. So if anybody is
9 hopefully no more confused, my
10 apologies. I know I had written on
11 the yellow sheets. You can
12 disregard the yellow sheets that
13 were passed out yesterday and that
14 were on the table today.

15 One other announcement is from
16 the New York Network guys. They
17 wanted me to ask you not to talk so
18 close to the microphone. It's
19 causing some interference. So just
20 don't talk too close to the
21 microphones.

22 And once again, my apologies.
23 Thank you.

24 MR. FAETH: No problem.

1 Thank you, Valerie.

2 I will also state before I
3 start. I should've mentioned it
4 earlier. I am a soft spoken person,
5 so don't be embarrassed if you can't
6 hear me or understand me. Just let
7 me know and I'll try to speak a
8 little clearer and louder.

9 Okay. Committee reports.
10 We'll start off with executive. I'd
11 like to thank Mr. Delagi for filling
12 in for me yesterday. We did have a
13 meeting since that meeting to go
14 over everything that they went over
15 and I'll touch base with the
16 different topics that were
17 discussed.

18 We are looking at, obviously,
19 trying to come to some conclusion
20 and correct the vetting process. We
21 spoke about the diversity TAG, EMS
22 state report card that was presented
23 earlier in the year, in which New
24 York State received a C+. We also

1 received high marks on different
2 aspects of that, but there is room
3 for improvement, obviously, and
4 there are things there that we're
5 going to look to try to address.

6 Paramedic licensure, which is
7 something that Mr. Marquissee
8 chaired a TAG that he headed up, did
9 an enormous amount of work on. And
10 he had to forward certain
11 recommendations. We would like to
12 actually see that to continue to
13 move forward and have those
14 recommendations realized.

15 And we'll probably talk a
16 little more on the one aspect of
17 that surveying the actual providers
18 out in the field, a little larger
19 survey than what was previously done
20 over at Vital Signs to get the
21 actual general feel from people that
22 do the work, from where they want
23 the systems to go.

24 And also communications,

1 hopefully, will begin with the
2 Department of Education and we'll
3 memorialize that in a letter to Mr.
4 Wronski. We'll try to move forward
5 with that, also.

6 Universal protocols. There's
7 still some discussions on that and
8 how it also sometimes may tie to
9 this -- the issues in regards to
10 medical control and the field
11 providers, speaking to a doctor or
12 not speaking to a physician in
13 certain regions and what issues
14 surround that.

15 On-scene triage, air medical
16 issues, inter-facility transfer
17 agreements, WMD reimbursements and
18 issues surrounding that, if God
19 forbid, something does happen in a
20 region and how providers are
21 reimbursed for what they have to
22 utilize and how they go forward with
23 that.

24 And obviously, just unfinished

1 projects that have been started,
2 some of what was stated here would
3 fall in that category.

4 Basically, as Dr. Henry had
5 stated earlier, we are being asked
6 to do more with less. We do realize
7 the economic impact of what's
8 happening, not only here but
9 globally and how that adversely
10 affects operations. But I know I
11 may be asking a lot, but it's -- I'm
12 still looking, hopefully, for this
13 body to continue to raise the bar
14 for what we do out in the field, not
15 lower it. I think that would be
16 inappropriate. We shouldn't be
17 moving backwards, we should be
18 moving forwards. Even under adverse
19 conditions, it is important at the
20 end of the day we provide the best
21 prehospital care that's available,
22 utilizing the resources and
23 equipment and technology that's
24 available. So that's pretty much

1 that in a nutshell.

2 I'll move on to -- I'm sorry,
3 any questions for executive? Okay.
4 We'll move on to medical standards.
5 I understand Dr. Marshall is
6 unavailable, but Dr. Henry will be
7 giving his report.

8 DR. HENRY: Dr. Marshall
9 was here yesterday, but he had to go
10 back last night. So I have four
11 motions, seconded motions, for your
12 consideration. Three of them have
13 to do with protocols, and at your
14 wish, we could do those together, if
15 there's -- if that meets your
16 pleasure. But let me lay those out
17 and perhaps we could put those on
18 the board.

19 All right. The first one was
20 the mid-state ALS protocols. There
21 were a few recommendations to the
22 region, which they accepted.
23 They're listed there on the board,
24 and as I said, they were all

1 accepted in the mid-state region.

2 So they accepted these revisions.

3 The next was Suffolk county's
4 region and again they accepted a few
5 minor revisions to the protocols.
6 One point I would highlight was that
7 the committee strongly recommended
8 that all advanced life support
9 agencies in Suffolk be capable of
10 carrying and using controlled
11 medication, especially for people
12 with seizures, as well as for
13 significant pain.

14 And they had also recommended
15 that if there is going to be
16 technology to detect carbon
17 monoxide, that regional resources
18 for hyperbaric oxygen be evaluated
19 and included. And Suffolk accepted
20 that.

21 And the last was Mountain
22 Lakes, which had a change to their
23 anaphylaxis protocol. And there
24 were some comments on that which

1 were acceptable, too, in terms of
2 wording.

3 So those are the three regions
4 that had protocols and came forward
5 as seconded motions to the council.

6 Is there -- are there any
7 questions about any of the three?
8 Would you call the question, then?

9 MR. FAETH: Call the
10 question to approve the minutes --
11 I'm sorry, not the minutes --
12 approve the protocol for the three
13 regions.

14 (Roll call vote taken.)

15 MS. OZGA: Motion passes.

16 DR. HENRY: Okay. Thank
17 you. The next motion that came
18 through SEMAC to you is approval of
19 a PAD course sponsored by the
20 Wilderness Medical Association.
21 That came to us as a recommendation
22 from the education sub-committee,
23 who reviewed the course and I don't
24 know if, Deb, if you want to say

1 anything about it, but --

2 MS. FULTS: No.

3 DR. HENRY: Okay. So we
4 voted to, you know, accept this
5 course as a PAD course from
6 Wilderness Medical Association, and
7 it comes to you, then, as a motion
8 for SEMAC.

9 (Roll call vote taken.)

10 MS. OZGA: Motion passes.

11 DR. HENRY: A couple
12 informational items. The council
13 and the Department and members of
14 the SEMAC had received letters from
15 a foundation called CARES, which
16 addresses the problem of congenital
17 adrenal hyperplasia. And they were
18 asking for consideration of
19 treatment for patients with adrenal
20 insufficiency in EMS protocols.

21 Deborah Brown, who is a member
22 of CARES foundation, presented
23 briefly to the SEMAC yesterday some
24 of the statistics about the number

1 of patients who have this condition
2 and their wish that SEMAC and
3 providers consider treating with
4 steroids patients who have adrenal
5 insufficiency, should they be
6 encountered in the field.

7 And SEMAC is going take this
8 up at our next meeting. And with
9 respect to the problem with the
10 congenital situation, EMS-C, Dr.
11 Cooper indicated, is going to
12 discuss it, as well. So you'll be
13 hearing more about that.

14 And the other item I just want
15 to highlight is we heard a report
16 from EMS-C regarding providers and
17 agencies, actually, perception of
18 medical control around the state.
19 It was of interest in terms of the
20 larger topic of who provides medical
21 control and it was also rich in
22 terms of including some providers'
23 perceptions of the -- what they have
24 in their respective regions.

1 So that's going to go to us
2 for further consideration about the
3 general topic that we've been
4 addressing overall and who provides
5 medical control in New York State.

6 So that ends the medical
7 standards report.

8 MR. FAETH: Thank you, Dr.
9 Henry. Both motions for the
10 regional protocols and the PAD
11 course were passed unanimously. No
12 objections.

13 We move on to finance. Ms.
14 Ellis or Dr. McEvoy, who will be
15 presenting?

16 DR. MCEVOY: I'll give the
17 report. The finance committee met
18 this morning. The secretary has the
19 attendance. And one note of
20 business was the templates. They're
21 going out to the program agencies.
22 That will go out in March, as usual,
23 and we decided to have those due
24 back on May 15th.

1 And hopefully we'll be able to
2 schedule a meeting for the committee
3 the night before the June meeting
4 begins in order to go over those
5 templates and put the budget
6 together, perhaps talk to Mr.
7 Wronski about that. And that's
8 probably why he's fleeing the room
9 right now.

10 The second item that we spent
11 most of the meeting this morning
12 discussing was we had mentioned to
13 you before that we were going to
14 undertake a review of the course
15 funding. And we were actually able,
16 myself and Nancy Benedetto, to
17 assemble with the help of the
18 bureau, about a five to six year
19 compilation of where training monies
20 have been allocated. And using a
21 smoothing process of the many years
22 of data, we actually created a pie
23 that we worked with this morning and
24 adjusted course funding numbers

1 based on a sponsor survey that had
2 been done last year by the finance
3 committee of core sponsors
4 throughout the state.

5 And essentially where that
6 leaves us at this point is we have
7 some idea of adjustments we want to
8 make. However we, in raising
9 certain rates, now need to spend
10 some time looking at where we're
11 going to take the money away from to
12 cover what we have raised, and that
13 will be our endeavor between now and
14 our next meeting, which we have no
15 intention of conducting behind
16 closed doors. So we'll figure out a
17 method of doing that so that it
18 invites public participation.

19 MR. FAETH: Thank you, Dr.
20 McEvoy. Any questions, concerns,
21 for finance?

22 Moving right along here.
23 Okay. Next on the agenda would be
24 education and training, Debbie

1 Fults.

2 MS. FULTS: Education and
3 training met yesterday. Our TAGs
4 gave the reports. I just want to go
5 over what TAGs we have out there
6 --the CLI curriculum TAG, the safety
7 TAG, the online courses TAG, ESCT
8 TAG and the educational standards
9 TAG.

10 And I just want to remind
11 everybody that the educational
12 standards are out in their final
13 form and you can get that on the web
14 under www.nemsis.org. The standards
15 are there and the instructional
16 guidelines for each level are also
17 on there.

18 And we do have people looking
19 at all of the sections of the
20 standards and comparing them to what
21 we have. So these committees are
22 continuing their work and hopefully
23 we'll have some finished products by
24 the June meeting.

1 Staff gave a report and I want
2 to go over some of the things that
3 they covered with us, that Karen
4 did, and an update on the testing
5 contractor. The RFP has been
6 received. It's scored and it has
7 been submitted for approval, so
8 we're just waiting.

9 Core sponsor letter went out
10 in December -- December 17, 2008 to
11 all the core sponsors and the
12 REMSCOs with some procedural and
13 recent updates. And I want to go
14 over those with you in case you
15 haven't seen them.

16 Under student application
17 deadline, when we used to have to
18 have the student applications
19 submitted six weeks prior to the
20 test date, that has been changed to
21 eight weeks before the date of the
22 written exam. And the bureau
23 strongly encourages that all student
24 applications be mailed to the bureau

1 prior to the third core session
2 unless the date falls after the
3 eight week deadline. And they will
4 accept applications of students who
5 enroll late, and after the core
6 sponsors are resubmitted, the
7 applications, as long as it is
8 before the eight week deadline.

9 So what happens if they get an
10 application after the eight week
11 deadline? The written exam for the
12 course will be moved to the next
13 available written exam date. The
14 current violation of financial
15 penalty procedures will continue to
16 be enforced.

17 When it comes to the student
18 applications themselves, sometimes
19 core sponsors hold onto those
20 student applications until the last
21 minute because some students drop
22 out or whatever and they don't think
23 that they have to submit them. And
24 this is a reminder that all students

1 who enroll in a course and are
2 present at the first session of the
3 course must complete and have
4 submitted to the bureau a student
5 application, regardless of whether
6 or not the student withdraws from or
7 fails the course.

8 Again, and I've reminded
9 everybody of this a couple times,
10 that make sure as core sponsors and
11 instructors that you review the
12 applications, that you make sure all
13 of the information is on there
14 correctly, dates of birth, the
15 spelling of their names, their
16 current address, and that any
17 unsigned student application must be
18 placed at the top of all student
19 applications that are submitted to
20 the bureau.

21 When it comes to the end of
22 the course paperwork and practical
23 skills exam, they must be submitted
24 in a timely manner. The bureau will

1 not certify any student unless they
2 have all end-of-the-course
3 paperwork.

4 And as a reminder, the
5 practical skills exam coordinator
6 must be a CLI or CIC and cannot be
7 the CIC of record for the course.

8 Student reference books and
9 protocols. There is an updated
10 protocol -- updated protocols on the
11 web. There's student reference
12 guides. They've requested to be
13 reprinted but they have not and
14 don't know if that will happen. So
15 in the meantime, sponsors should
16 provide either a paper copy or a
17 computerized file of the protocols
18 to all students and the reference
19 manual, if you can. Sponsors may
20 charge a nominal fee to the students
21 to cover expenses only.

22 Certified instructors. Please
23 remind all of your certified
24 instructors that they need to notify

1 the bureau whenever they have a
2 change in their mailing address or
3 telephone number. The bureau has an
4 increasing number of instructor
5 renewals being returned as
6 undeliverable due to changes in
7 address.

8 And one more thing on that
9 topic is that the exam tickets. If
10 you remember the exam tickets are
11 sent to the instructors. So if
12 there -- if you have a wrong
13 address, you may not be getting
14 those exam tickets.

15 Are there any questions for
16 education and training? That's the
17 end of my report.

18 MR. FAETH: All right.
19 Thank you, Deb. We will move to
20 peer and Mr. Czapranski.

21 MR. CZAPRANSKI: Thank
22 you. Peer met yesterday and comes
23 with no seconded motions. Donna
24 Girard gave the staff report and has

1 the meeting attendance.

2 EMS week, again, just to
3 reiterate from last meeting, is May
4 17th to 23th. And to reiterate Mr.
5 Wronski, the EMS memorial, which we
6 had looked at as the 20th, is
7 actually Thursday, May 21st.

8 Vital Signs, October 15th
9 through 18th in Rochester, New York.
10 The awards have to be postmarked by
11 August 1st and sent in to the EMS
12 bureau. Love to see all the REMSCOs
13 submit this year. We typically have
14 one, two or three REMSCOs that don't
15 submit anybody for awards, so we'd
16 love to see everyone -- all the
17 REMSCOs reflected in the awards
18 process.

19 We have several continuing
20 projects. We have the EMS logo on a
21 pin which we hope to have available
22 by Vital Signs. We have a
23 recruitment poster, which again,
24 anybody who has any high end

1 e-pictures, electronic pictures they
2 want to send to us, please do so.
3 We'll be trying to do a collage in
4 June for a September poster.

5 We also have a recruitment
6 video we're looking at, getting
7 several film schools together to
8 talk about the best way to develop
9 and produce a recruitment video for
10 up and coming EMS providers or
11 hopefuls.

12 We also have a children's play
13 which we're re-looking at to see
14 whether it's important to move
15 forward with that or we can couple
16 it with a book or other project.

17 That's all for the peer,
18 unless there are any questions.
19 Thank you.

20 MR. FAETH: Thank you,
21 Tim. Actually, one region did send
22 me some e-pictures, so I will
23 forward that over to you. But
24 seriously, if anybody else has some

1 electronic photographs of your
2 agency, you know, your staff or your
3 particular region, try to get that
4 over to Tim and we'll get this thing
5 moving.

6 I'll move on to evaluation. I
7 believe Mr. Delagi will be giving
8 that report.

9 MR. DELAGI: Thanks, Mr.
10 Chair. The committee met yesterday.
11 The secretary has the attendance.
12 No seconded motions to come forward.

13 Before I give the final
14 report, though, I did want to just
15 acknowledge very briefly the work of
16 Catherine O'Connor, who was a
17 non-council committee member who
18 served with our committee, who was
19 very active and was very helpful in
20 a lot of the work products that
21 you've heard us talk about
22 throughout the course of the last
23 two years. Catherine has moved on
24 to take another job within

1 Westchester County government and we
2 look forward to working with Dan
3 Almos, her replacement, who expects
4 to join the committee as soon as we
5 can get him approved.

6 Ms. Burns gave the staff
7 report at our meeting, upon which
8 time we learned that the 2006 PCR
9 data disks have been sent to all the
10 regions and the bureau is currently
11 working with the keypunch contractor
12 to get '07 and '08 PCR data sets out
13 faster.

14 She also provided an update on
15 the progress of Phase I of the
16 Governor's highway traffic safety
17 board grant that was received in
18 late 2008. Eight RFIs were received
19 and are currently being reviewed and
20 you will recall that year one of
21 this three-year grant cycle will be
22 used to benchmark services and state
23 information technology to see what
24 is currently in place across the

1 state to identify comprehensively
2 all forms and types of electronic
3 PCRs that are being used.

4 And our committee has been
5 asked to work with the bureau to
6 develop a NEMSIS compliant receiving
7 platform, which will be capable of
8 receiving a variety of electronic
9 media going forward.

10 The executive summary.
11 Describing the results of the QI
12 survey that we had done at Vital
13 Signs '08 has been prepared and was
14 reviewed at yesterday's meeting and
15 our plan is to send that out to each
16 of the regional program agencies for
17 their use in personalizing for their
18 region and distributing to their
19 respective squads. The goal of
20 this, obviously, is to offer ongoing
21 guidance to services for
22 establishing and maintaining CQI
23 initiatives, and this again was done
24 as a result of the survey results

1 from the rank and file EMS
2 providers, where we tried to gauge
3 their understanding of the process
4 and what was going on in their
5 respective services.

6 We've actually asked the
7 bureau staff to enhance this process
8 through the local service inspection
9 efforts to identify best practices
10 and gaps in quality improvement.

11 And certainly in the spirit of
12 quality improvement, this endeavor
13 is not designed to be punitive in
14 nature but rather educational, so
15 that we can get a handle on exactly
16 what's going on at the service
17 level.

18 In recognizing that there are
19 gaps that still exist in data
20 sharing between hospitals and
21 ambulance services, we've asked that
22 a hospital's preparedness bureau
23 representative be invited to attend
24 our June meeting to discuss

1 information sharing barriers that
2 may or may not exist between
3 hospitals and ambulance services.

4 And we maintain the very
5 strong position that without getting
6 outcome data, it is very, very
7 difficult to do meaningful, quality
8 improvement. There may or may not
9 be barriers. It's up to individual
10 perceptions and we want to try to
11 identify what the issues are if they
12 do, indeed, exist and propose some
13 solutions.

14 As you heard earlier, we did
15 receive the New York State report
16 card on healthcare and our committee
17 worked to identify twenty-two
18 different data elements that all
19 have EMS system implications. We
20 will be conducting a further review
21 of the data that actually led to the
22 scores in those twenty-two
23 categories and we will have a report
24 for you at our next meeting in June.

1 And similarly, we're
2 continuing progress on collecting
3 information on our other EMS system
4 data points that we've been talking
5 about. And we'll be able to report
6 to you in June on that, as well.

7 As part of the ongoing
8 discussion about medi-vac services
9 and the safety initiative, we are
10 going to invite a member of the STAC
11 to sit on our committee and we'll
12 have to talk about logistically how
13 best to do that, but we would very
14 much like STAC to become part of our
15 committee, initially to look at
16 outcome data on the patients that
17 were flown to trauma centers by
18 helicopter in the survey that we
19 conducted last year and certainly
20 going forward to maintain a healthy
21 relationship with the STAC on
22 collecting data on trauma outcomes
23 in general.

24 This is being done in an

1 effort to support our region's
2 appropriateness and use studies by
3 providing clinical outcome data to
4 the degree possible.

5 And similarly working with our
6 folks on our contribution to the
7 online medical control discussions
8 by the survey results that we
9 obtained from program agency
10 directors, where we were able to
11 identify that in seventy-five
12 percent of the regions, providers
13 talked directly with a physician,
14 either as the first person they
15 encounter on the telephone or after
16 the call has been triaged by an
17 EMT-CC, an EMT-P or a nurse.

18 And in twenty-five percent of
19 the regions, there is no physician
20 consult. It's provided by another
21 licensed practitioner. So that is
22 added to the data that EMS-C
23 presented and the ongoing
24 discussions with online medical

1 control.

2 And that is it for our report,
3 unless there are any questions.

4 MR. FAETH: No questions
5 for Bob?

6 MR. WRONSKI: Just a
7 comment to add to Bob's report. We
8 do know about the issue of the
9 difficulty of sometimes getting
10 hospitals to share data with EMS in
11 their QI/QA.

12 Myself, and while she was with
13 the bureau, Marjorie Geiger, sat for
14 it seems like three years, but I
15 think it's only two, on a cardiac
16 advisory committee to rewrite
17 cardiac regs, not just STEMI regs,
18 which is the real reason I sat on
19 this committee, but also a total
20 rewrite of cardiac regs.

21 And a draft of those
22 regulations for the 405 hospital
23 regulations were provided to the
24 SHRPC recently for review and

1 discussion and that is the
2 preliminary stage before final regs
3 are prepared and then put into a
4 published state.

5 And in that, in those
6 regulations, there is language that
7 we collaboratively developed which
8 includes a statement that says
9 hospitals may release
10 patient-specific data to EMS QI
11 processes, specifically as referred
12 to in 3004 of the existing article
13 30.

14 And so once that's in, even
15 though currently we think there can
16 be an exchange of data, this will
17 solidify and put aside a lot of the
18 concerns that have been raised by
19 different hospitals and their
20 councils.

21 So I expect that to be in
22 place sometime this year. And you
23 might see a more cooperative
24 compliant -- it doesn't mean you're

1 going to get, by the way, a patient
2 chart. That's not really what it
3 means. But it does mean they'll be
4 able to share outcome data with you
5 more freely and they'll be more
6 comfortable to do so because there
7 will now be something in the 405
8 hospital regulations very directly
9 addressing that.

10 MR. DELAGI: Thank you,
11 and that certainly does indeed help.

12 MR. FAETH: Thank you
13 both. Next on the agenda, we are
14 going to move to EMS systems, Andrew
15 LaMarca.

16 MR. LAMARCA: All right.
17 Thank you. Systems committee met
18 yesterday and the secretary has the
19 attendance. We also have no
20 seconded motions to bring forward.

21 We did start the meeting with
22 a report from the EMS for Children's
23 report on the survey that they had
24 completed, which did include both

1 transporting and non-transporting
2 units. And there is some
3 benchmarking as far as the equipment
4 standards that are established that
5 we'd like to try to meet. And I
6 think that some of the figures seem
7 to be a little bit low in certain
8 areas where we do statutorily carry
9 some equipment, but it included
10 non-transporting services. So the
11 next pass will have just
12 transporting services, so that
13 statistic might be a little more
14 valid across.

15 The TAG we have outstanding,
16 which is the communication TAG with
17 Ray Serowik and Dana Jonas, did
18 report on the failure of the
19 statewide wireless network, which
20 that part ceased.

21 We did distribute a report
22 from the New York State office of
23 technology from the chief
24 information officer detailing

1 nineteen or twenty deficiencies that
2 were cited which were unsolvable and
3 that led to the termination of that.
4 Dana has reached out to try and find
5 out where this goes to now,
6 particularly in areas of
7 inoperability, and has yet to
8 receive any verification from them.

9 On a more positive note, they
10 did distribute an EMS radio project
11 report from Franklin County, which
12 for a fairly modest fee of \$150,000
13 it looks like, has gone a long way
14 in trying to address the
15 inoperability issues in their county
16 and certainly something that should
17 be commended.

18 We did hear a report from
19 staff, first leading off with the
20 matter of the City of Utica.
21 Mid-state had held their hearing and
22 determined -- they had made the
23 determination that no need existed.
24 The Department has received notice

1 from the City of Utica of an appeal
2 to that action. The Department has,
3 again, just received that notice and
4 has acknowledged it and does not
5 have the grounds yet.

6 And once that whole packet is
7 received, they will start assembling
8 all the information necessary to
9 turn it over to the Administrative
10 Law Judge, which will now also
11 include the copy of the simulcast of
12 that hearing, as well. And from
13 what staff has indicated, probably
14 the first time we might see this
15 formally may be as late as the
16 September meeting this year here.

17 In other issues, we have had
18 -- there's three municipalities that
19 either declared their intent to
20 cease operating an ambulance or
21 rescinded their intent to operate
22 one. That includes the City of
23 Batavia, the Town of Pawling and the
24 Village of Pawling. In addition,

1 one service, the Town of Marlborough
2 volunteer ambulance service has
3 surrendered its operating permit.

4 The issues that have come up
5 recently with municipal CONs have
6 led to a new policy or an updated
7 policy, 0901, to clarify what's
8 necessary for the municipal's CON
9 process, both in the initial stages
10 and after two year conversion, the
11 process of the CON. That is already
12 on the website.

13 Other than that, that was the
14 more significant matters in front of
15 us.

16 MR. FAETH: Thank you,
17 Andy. Any questions for systems?

18 MR. LEWIS: Question maybe
19 for Mr. Wronski regarding the City
20 of Utica and will they be extended
21 the opportunity to continue to
22 function now that this decision has
23 been made by the EMS council on a
24 fifteen to five vote or something

1 like that?

2 MR. WRONSKI: The answer
3 is one that I'll also clear with our
4 counsel's office, but it's one which
5 I freely give because I think it's
6 important. That is, during the
7 pendency of the administrative
8 hearing, the decision by this body
9 that the Utica ambulance service
10 would continue to operate and to
11 wait to hear the decision of the
12 SEMSCO as to whether or not they
13 support the regional decision or
14 not.

15 MR. LEWIS: I just have a
16 question regarding that. When it
17 comes to an ambulance service to
18 have the ability to invoice Medicare
19 and Medicaid, they must have a valid
20 CON. And as we talked about this at
21 a former meeting, there is no
22 statute providing that the CON can
23 be extended, as I thought it was
24 said at that time. Are we putting

1 the residents in the City of Utica
2 at risk for paying back Medicaid and
3 Medicare dollars thinking they're
4 continuing to bill, because that's
5 the reason they stated they're in
6 the business? Are we putting the
7 residents at risk of paying back
8 these dollars should the ALJ uphold
9 the regional council decision?

10 MR. WRONSKI: In my
11 opinion, no, as Medicaid and
12 Medicare will look for the state
13 license, which will indicate to them
14 is still in effect. If he were to
15 rescind that as the agency that has
16 authority over that operating
17 certificate, then it would probably
18 affect the billing capabilities.

19 But we would be advising them
20 that we're allowing them to continue
21 to operate as a legally-functioning
22 ambulance service during the
23 pendency, again, of the
24 administrative hearing.

1 MR. LEWIS: But you said
2 there is no statute allowing the
3 provision for an extension. Am I
4 correct on that or not?

5 MR. WRONSKI: There is no
6 specific statute for the extension
7 that specifically addresses -- that
8 states there can be an extension.
9 That's correct.

10 MR. LEWIS: Thanks. Thank
11 you.

12 MR. FAETH: Thank you.
13 Any other questions for systems?
14 Okay. We'll move the agenda to
15 legislative, Mr. Lewis.

16 MR. LEWIS: Yes. Thank
17 you very much. We -- our meeting
18 was yesterday afternoon. The
19 secretary has the attendance record.

20 A couple of things. We
21 reviewed sixty-two newly introduced
22 pieces of EMS -- EMS relative
23 legislation, and there is one
24 seconded motion that came out of the

1 committee and I think it's going to
2 be up on the board, the motion to
3 oppose a piece of legislation that's
4 out there which we think, and I'm
5 sure others will agree, will
6 negatively impact physicians in the
7 State of New York.

8 And as we've had meetings over
9 the past couple of days and there
10 are concerns about enough
11 specialities -- specialty physicians
12 available in many communities, this
13 piece of legislation, we feel, will
14 exacerbate that problem. It's
15 Senate 1729 and Assembly 4627.

16 I have a letter from the New
17 York chapter of the American College
18 of Emergency Physicians in
19 opposition to this, because it will
20 -- the end result will be another
21 \$150,000,000 a year in cost to
22 medical malpractice premiums for
23 physicians.

24 The other part of this that's

1 uncertain -- uncertain to the
2 ambulance industry is whether or not
3 we're impacted on this and if the
4 ambulance industry is also impacted
5 with insurance or the availability
6 of medical directors. Because of
7 this malpractice -- additional
8 malpractice insurance, it could be
9 devastating to the EMS system across
10 the State of New York.

11 So Senate 1729 and Assembly
12 4627. It's Snyderman introduced and
13 Weinstein also was on the bill from
14 the Assembly. It's an act to amend
15 the civil practice law and rules in
16 relation to the limitation of time
17 within which an action of medical,
18 dental, podiatry, malpractice
19 accrues, and providing for one year
20 revival of previously dismissed
21 actions.

22 I would ask this body to
23 strongly oppose this legislation and
24 that that be shared with the

1 Commissioner.

2 MR. FAETH: Okay. We have
3 a seconded motion on the floor to
4 oppose Senate bill 1729 and Assembly
5 bill 4627. Do you have any
6 discussion? Yes, Dr. Cooper.

7 DR. COOPER: For the
8 record, the American College of
9 Surgeons of New York State and
10 District 2 of the American Academy
11 of Pediatrics have also gone on
12 record as opposing this legislation.

13 MR. FAETH: Thank you, Dr.
14 Cooper. Any other further
15 discussion? Okay. This does not, I
16 believe, require a roll call vote.
17 I believe, show of hands. All in
18 favor of opposing this legislation,
19 aye?

20 SPEAKERS: Aye.

21 MR. FAETH: Any opposed --
22 any against the motion to oppose?

23 MR. LEWIS: One more piece
24 of legislation, Mr. Chairman.

1 MR. FAETH: Any
2 abstentions?

3 MR. LEWIS: Oh, I'm sorry.

4 MR. FAETH: Okay. It
5 passes unanimously.

6 MR. LEWIS: It's that soft
7 spoken voice.

8 A piece of legislation to be
9 watchful of, which was discussed at
10 length by our committee, is A-02788
11 and S-02220. And we're seeking more
12 information from the sponsor on
13 this.

14 This -- it states, Establishes
15 the requirement for the provision of
16 ambulance services to senior living
17 facilities. There is mixed language
18 on this. It sounds like, in some
19 ways, that the legislation is
20 stating that any new senior living
21 facility that has more than fifty
22 people must have an ambulance
23 service on site, which makes
24 absolutely no sense.

1 And then there is language
2 that leads us to believe that maybe
3 it's just a contract with an
4 ambulance service, to be certain
5 they perspectively plan, which makes
6 some sense.

7 So what we are looking for
8 before it comes back to legislation
9 for consideration is we will be
10 contacting the sponsor to ask just
11 what's driving this.

12 We did talk to a couple of
13 other members of this body and it
14 appears that these senior living
15 centers pop up, if you will, and in
16 an area where a volunteer ambulance
17 corps may do five or six or seven
18 hundred calls and all of a sudden
19 this new facility doubles their
20 responses, which has a big impact on
21 those services.

22 So I'm thinking that once we
23 have appropriate information, I
24 think we need to take action on this

1 bill. But I'd like to ask you to --
2 if you have comments, I'd love to
3 hear them. If there are no
4 comments, we'll bring it back to you
5 next month or next time.

6 MR. FAETH: Could you
7 please repeat the bill numbers?

8 MR. LEWIS: Sure. It's
9 A-02788 and S-02220 in the senate.
10 It can be disturbing what's
11 occurring here and we'll keep you
12 informed. If there's others that
13 have more information on this bill,
14 it would be appreciated.

15 MR. FAETH: Any other
16 questions for Mr. Lewis? Seeing
17 none, we'll move the agenda to
18 safety TAG, I believe Mr. Warren
19 Darby will be presenting.

20 MR. DARBY: Safety TAG did
21 meet. We had sixteen present at the
22 meeting yesterday afternoon. We
23 talked a little bit about getting
24 ready for a second year annual

1 presentation for Vital Signs, having
2 our first at the 2008 Vital Signs.
3 And it is our intent to always have
4 a presentation at the annual
5 conference to keep the culture of
6 safety discussed.

7 We are looking -- a couple of
8 us are looking at the fire safety
9 officer's course, which is a
10 curriculum that's in place and being
11 utilized by the State of New York to
12 see if we can come up with a program
13 similar for the EMS side of the
14 house, and we will be reporting back
15 on that in the future.

16 We had given to us in both the
17 systems meeting and in the safety
18 TAG meeting a reportable incident
19 form, New York State form number
20 DOH-4423, which is in draft form.
21 It's not out yet, but it was the
22 first solid copy that we have to
23 react to on a piece of work that
24 we've been working on for about a

1 year to get a database in place at
2 the central office that would have
3 specific reportable incidents as
4 required in part 800 on a form
5 that's available to all of us.

6 Those that were not in either
7 of those sessions yesterday and
8 would like to have a copy of this
9 form, just let Lee Burns know and
10 she'll send it right out to you.

11 There is some beta testing
12 going on right now with the database
13 for that information at the central
14 office and hopefully down the road a
15 PDF file available over the
16 different sites, regional sites, so
17 that you can download, fill it and
18 send it in to central office
19 directly, electronically. There is
20 some regions that have regional
21 databases right now. Western is
22 probably the foremost in that
23 process, as we speak.

24 We then got into a pretty good

1 open think brainstorming session on
2 the EMS safety best practices
3 document that we'd like to come up
4 with that we could give to any
5 person at any of the EMS agencies to
6 look and see what's being done
7 across the state for safety within
8 their -- an EMS agency and what
9 might they do. During that
10 discussion, we had a lot of issues
11 talked about regarding lifting and
12 moving, vehicle operations, the
13 mobile workspace in the rig itself,
14 sharps, the scene operations,
15 managing violent scenes.

16 All of that was discussed and
17 Dr. Cooper, in his inevitable way of
18 coming up with information, that
19 kind of put it all together. He
20 came up with an acronym called
21 SPINS, so it was kind of a new spin
22 on the safety piece of EMS. And
23 SPINS stood for "S" Situation, what
24 is it we got that we're in. "P"

1 what kind of Protection do we need
2 to be taking for ourselves and our
3 partners, 'cause if we don't take
4 care of ourselves, we can't take
5 care of anybody else. "I" for
6 Isolation when that's necessary for
7 all parties involved there. And "N"
8 for Notification as is necessary for
9 that particular event.

10 We're going to continue to
11 work on this document and hope to
12 come forth with a written draft for
13 the council to see in the near
14 future. But what we're saying is
15 the old -- is the scene safe and
16 BSI, which is something we routinely
17 reported in every practical session
18 should probably be -- there's no
19 scene that's safe.

20 Have we all identified -- as
21 we're looking at that scene around
22 and looking at the situation, have
23 we identified the hazards that can
24 hurt us, and that's the approach

1 we're taking right now.

2 More to come. Be safe out
3 there.

4 MR. FAETH: Thank you, Mr.
5 Darby. Thank you, Mr. Bishop, also,
6 and the committee for all the hard
7 work you're doing. Recent tragic
8 events remind us how important it is
9 to be conscious of safety.

10 We move the agenda then to
11 EMS-C. I believe Sharon Chiumento
12 has a report to give.

13 MS. CHIUMENTO: Thank you.
14 We are running a meeting next month
15 on March 17th, so we haven't had a
16 lot of activity since our last time
17 with you. However, I do want to the
18 report that from our last meeting in
19 December, that Dr. Cooper was
20 elected as our chair and Dr. Lillis
21 from the western region has been
22 elected as our vice-chair. Both of
23 them have now been vetted, so
24 they're waiting for their letters of

1 appointment.

2 We also have been notified
3 that our white paper on the
4 regionalization of critical
5 pediatric hospital services has been
6 reviewed by Dr. Daines and he has
7 authorized us to go forward and have
8 a stakeholder's meeting to move
9 forward with that particular
10 process.

11 We had a wonderful
12 presentation at our last meeting on
13 emergency preparedness for
14 pediatrics and OB patients. The
15 Department has developed a wonderful
16 tool kit, which is available on the
17 Department of Health website. If
18 you would like further information
19 on that, I'm sure Martha Gohlke
20 would be glad to give you more
21 information about how to access
22 that.

23 We have two new
24 sub-committees, one on education and

1 looking at education related to
2 pediatrics. Ann Fitton from the
3 Fire Department of New York is going
4 to be chairing that committee.

5 And the second committee is on
6 inter-facility transports, which
7 kind of goes along with some of the
8 issues we've discussed here at SEMAC
9 in the past. I will be chairing
10 that committee and we are looking at
11 developing a guideline template for
12 inter-facility transport for
13 pediatric patients.

14 Other future projects that
15 we'll be working on are disaster
16 preparedness. We hope to develop a
17 card similar to the cards that we
18 developed on pediatric assessment
19 and on special healthcare needs
20 patients. So we are hoping to do
21 one on pediatric patients and caring
22 for them during disasters.

23 And also we're working on a
24 white paper on EMS-C in New York

1 State and what our future projects
2 should be.

3 EMS-C members are also working
4 with STAC on developing pediatric
5 components of the hospital trauma
6 regulations and we are working with
7 STAC and SEMAC on a letter hopefully
8 adding trauma surgeons and pediatric
9 specialists to the Doctors Across
10 New York State funding.

11 Do you have any questions?

12 MR. FAETH: If there's no
13 questions for Sharon, thank you
14 Sharon. Does the state trauma
15 committee have a report? Dr.
16 Cooper.

17 DR. COOPER: Thank you.
18 The State Trauma Committee -- State
19 Trauma Advisory Committee did meet
20 last week. It was unable to enact
21 official business due to conflicts
22 in attendance of many of the key
23 members of the committee.

24 However, a good deal of

1 progress was accomplished with
2 respect to a large number of tasks.
3 Consideration was given to a process
4 by which impact of trauma center
5 closings on the public health could
6 be discussed. Review of potential
7 additional data points to the trauma
8 registry was discussed. The scope
9 and content of next year's
10 educational offering at the Vital
11 Signs conference was presented and
12 thought to best be focused on
13 traumatic brain injury.

14 And as always, great
15 consideration was given to the
16 nature and frequency of the
17 statewide trauma reports that are
18 issued, as well as the site visit
19 process.

20 The latter two are recognized
21 at some level as being dependent
22 upon the timely submission of
23 complete data to the state trauma
24 registry and analysis of that data,

1 since outcomes are central to the
2 trauma system in terms of its
3 success.

4 To that end, a small working
5 group has been convened to look at
6 the issue of how individual trauma
7 center reports submitted on an
8 annual basis, documenting outcomes,
9 might be used to create a statewide
10 interim data report between the
11 multi-year analyses that have been
12 characteristic of the program in the
13 past.

14 So I think it was an extremely
15 productive meeting, and although no
16 formal actions was taken on any of
17 these items, a tremendous amount of
18 progress was made toward reaching
19 many of these goals. And I think we
20 all expect that the June meeting
21 will result in formal adoption of
22 many, if not all of the items that
23 were discussed at this most recent
24 meeting.

1 Sharon Chiumento has already
2 commented on the fact that an
3 interim meeting of the group that
4 has been working at the direction of
5 the STAC to develop potential
6 regulatory changes consistent with
7 the policies that the STAC has
8 already adopted did meet in January,
9 focused chiefly upon pediatric
10 issues but was able to spend quite a
11 bit of time refining some of the
12 other points, particularly with
13 respect to sub-specialty coverage.
14 I think we're all very hopeful that
15 that process will be soon drawing to
16 a conclusion.

17 MR. FAETH: Thank you very
18 much, Dr. Cooper. Anybody have any
19 questions for trauma committee? Dr.
20 McEvoy?

21 DR. MCEVOY: Dr. Cooper,
22 we made a referral to STAC several
23 months back about tourniquets. Do
24 you know if that's moved forward at

1 all?

2 DR. COOPER: I do not, but
3 Mr. Wronski, if it is not
4 inappropriate to query Dr. Marx
5 about progress in this area and post
6 it on the SEMSCO list serve, I will
7 do so for the edification of all
8 concerned.

9 I do not believe that any
10 formal review of that issue has been
11 brought before the STAC, although I
12 can tell you that there have been
13 literature of use performed with
14 respect both to tourniquets and
15 hemostatic agents that will allow
16 us, I believe, to develop some
17 information to bring back to medical
18 standards in the not too distant
19 future.

20 DR. MCEVOY: Thank you.

21 MR. WRONSKI: We'll follow
22 up with Dr. Marx. There was nothing
23 presented at this meeting, because
24 as Dr. Cooper said, there was,

1 unfortunately, a large number of
2 physicians who could not make the
3 meeting and this had been put on the
4 work agenda of the STAC for that
5 meeting.

6 There were at least one
7 physician who was going to do
8 research on this, but we don't have
9 any reports yet.

10 MR. FAETH: Okay. Thank
11 you. If there is nothing further
12 for trauma, we are pretty much done
13 with committee reports.

14 Any unfinished business, old
15 business? Oh, I'm sorry. I
16 apologize. I have a report from the
17 diversity TAG.

18 MR. CZAPRANSKI: Thank
19 you. As you know, this is a new
20 committee and we have no motions to
21 bring forth.

22 The final committee
23 development is still in process. As
24 Mr. Wronski indicated, we are

1 looking for members who are
2 interested in this project.

3 Mr. Wronski sent out a letter
4 on June 24th to the REMSCOs. All of
5 the REMSCOs but three responded to
6 that letter. We're going to
7 double-check to make sure those
8 three responses weren't misplaced
9 somewhere, and if indeed they are
10 missing and they did not respond,
11 we'll reach out to those three
12 REMSCOs and ask them to fill out and
13 respond to the request in Mr.
14 Wronski's letter.

15 The responses by the REMSCOs
16 clearly indicate that they have done
17 a stellar job of meeting the
18 requirements of article 30, and I
19 think that that is sort of something
20 that we all knew intuitively, but
21 it's nice to hear back that that has
22 been addressed and their comparison
23 to the detail of article 30 was very
24 complete.

1 However, we need to look a
2 little bit deeper. Our committee is
3 being designed basically to provide
4 support to the REMACs and the
5 REMSCOs around the state as it
6 relates to the diversity issue. We
7 don't know where we are. We don't
8 know where we are and we need to
9 perform measurements locally and as
10 an aggregate to the state to
11 determine where our starting point
12 is. We need to identify
13 limitations.

14 Some of those were outlined in
15 the letters or the responses to Mr.
16 Wronski's letter identifying lots of
17 limitations that many of the REMSCOs
18 don't select their members, they're
19 selected by outside agencies.
20 Representatives are sent to the
21 REMSCOs.

22 We need to have the REMACs and
23 the councils look at adopting a
24 local policy to address this issue.

1 We need to identify past and current
2 opportunities, those that have
3 failed and those that are
4 successful. Many of them have
5 designed projects to build in
6 diversity into their communities and
7 into EMS and we need to look at
8 what's out there, find out how well
9 it worked and look at best
10 practices.

11 We also need to look outside
12 of EMS. This is an issue that's
13 been wrestled with in many facets,
14 law enforcement, medical schools,
15 etcetera. So there is a lot of
16 information out there to help us
17 through this process. We hope to
18 have a full committee in June and
19 we'll report from there.

20 There are some short-term
21 opportunities, and while they exist,
22 this is really a long-term project
23 and many REMSCOs have identified and
24 undertaken action steps and we look

1 forward to hearing a follow-up from
2 those REMSCOs about those action
3 steps and see how successful they
4 were.

5 Unless there are any questions
6 or any comments by Mr. Wronski?

7 MR. WRONSKI: Just that I
8 appreciate Mr. Czapranski taking on
9 this task and look forward to
10 working with him and all of you on
11 this effort.

12 As I said at his committee, I
13 see it as a positive issue for us to
14 tackle in our changing communities
15 and our changing healthcare systems
16 and make sure we're all inclusive in
17 reaching out to our population and
18 bringing people into our systems.

19 But I also see this as an
20 opportunity for councils to
21 constantly re-evaluate themselves,
22 simply because you should be doing
23 that and it's important to stay
24 healthy as a counsel, that you

1 re-evaluate your membership, who is
2 on your committees, and have
3 periodic changes in membership so
4 that you adequately represent and
5 get your community involved.

6 So again, I appreciate Mr.
7 Czapranski taking this on and we've
8 got a lot of work to do and I think
9 the committee will be very
10 successful over the next few months.

11 MR. FAETH: Thank you very
12 much. Any other questions,
13 concerns? Yes, Mr. Reisner.

14 MR. REISNER: I don't
15 believe I heard a report on the
16 status of blood.

17 DR. HENRY: That's an
18 important point and I'm sorry. I
19 forgot to mention that. There was a
20 letter dated the 30th of January,
21 co-signed by Mr. Wronski and Dr.
22 Linden, that had draft regulations
23 that would include ambulance
24 services as a unit that would

1 transfuse blood products.

2 So I would urge you all to
3 look at those regulations and ask
4 the questions, how does this work
5 practically so that the language
6 doesn't trip up the intent of making
7 blood available to people who need
8 it when they're moving from one
9 place to another.

10 So there is two opportunities
11 to make comments. One is before the
12 28th of this month and you can
13 direct those comments to Mr.
14 Wronski. And then afterwards,
15 you'll be able to respond when
16 they're published for a wider
17 comment.

18 But I think the opportunity is
19 to do it now. So if you have
20 practical questions like what is
21 this refrigeration requirement,
22 who's going to provide that, do I
23 have to do that, what type of forms
24 are the state forms, can we see

1 drafts of what's proposed there,
2 those are the pragmatic questions.

3 Who is the director of the
4 ambulance service that I have to
5 require? Do I have to have
6 agreements with fifty hospitals or
7 can I have them with one or two?
8 Those are the questions you have to
9 ask yourself so this works.

10 So it's moving forward. We're
11 making it happen. I think it's
12 better to do it with the blood bank
13 people. They brought up safety
14 concerns that we probably wouldn't
15 have thought of, which are good to
16 have in mind. But we don't want to
17 get tripped on the language. So --

18 MR. REISNER: For the
19 viewing public, is that document
20 online anywhere?

21 MR. WRONSKI: Actually, I
22 don't know if it is. The document
23 was sent electronically to all
24 council members and to all SEMAC

1 members. It was also sent to, I
2 believe, blood bank people and I
3 believe to some hospitals or all
4 hospitals.

5 DR. FUNK: All ED
6 directors.

7 MR. WRONSKI: All ED
8 directors. Okay. And for comment,
9 but it wasn't to my knowledge put
10 directly on a website. And the
11 reason really for that is that it
12 was a focused audience for the first
13 comments, the people who work with
14 it most directly or would work with
15 it most directly.

16 And then after we get your
17 comments, we'll modify what we feel
18 we need to modify and then put out a
19 final set of regs, which would then
20 go into the public comment period
21 and would be for everyone.

22 But at this stage, it is a
23 first pass to the organizations and
24 entities and healthcare, who are the

1 biggest stakeholders.

2 MR. FAETH: Okay. Thank
3 you, Dr. -- Mr. Wronski, Dr. Henry.
4 I think I'll classify that question
5 by Mr. Reisner under unfinished
6 business and not under diversity.

7 MR. REISNER: Oh, okay.

8 MR. FAETH: Any other
9 questions with diversity issues?
10 Okay.

11 And continuing with unfinished
12 business, anything anybody wants to
13 see resurrected, brought up,
14 completed? Anything? Going once,
15 going twice. Okay.

16 New business. Do we have any
17 new business on the floor? Okay.
18 I'll lead off, since everybody's
19 shy.

20 One of the things that -- we
21 had a meeting a couple weeks ago,
22 Mr. Wronski, myself, Dr. Henry. One
23 of the things that we recognize is
24 the fact that although we have great

1 attendance here, and thank you all
2 for coming out, there are some
3 members who are here in name but not
4 here in person.

5 And if you read through your
6 SEMSCO bylaws, it's stated very
7 clearly that if you miss two
8 consecutive meetings, the state will
9 send you a letter -- should send you
10 a letter asking for what your
11 intention is. And if your intention
12 is to stay on, you know, please make
13 the effort to do so and participate.
14 But if it's just to carry the title,
15 you'll be asked to resign, step down
16 and let somebody else step up,
17 because we need to always have a
18 quorum and we have a lot of work to
19 get done and obviously many hands
20 make light work. So that's one of
21 the things that I wanted to put
22 forward, and if you have any
23 questions about that or if you need
24 a copy of the bylaws, it is on the

1 DOH website.

2 MR. QUINN: Does that mean
3 if I skip the next two meetings,
4 that my successor will be vetted and
5 seated?

6 MR. FAETH: That's a good
7 point, Mike.

8 And the second piece of new
9 business, I have a homework
10 assignment for -- mandatory for the
11 chairs and optional for everybody
12 else in this room and anybody at
13 home that's listening and watching
14 this.

15 I would like you, before March
16 1st, to e-mail me what you consider
17 to be the three biggest problems
18 that we have facing EMS systems
19 today. And along with that, I would
20 like your recommendations of what
21 you feel should be done to correct
22 those three biggest problems.

23 I don't obviously operate in a
24 vacuum. I need your input. And as

1 I stated earlier, I obviously
2 haven't cornered the market on
3 knowledge, so I would appreciate
4 your input on this. I will be
5 reminding definitely all the chairs
6 to do this. I think it's important
7 that we all be on the same page and
8 that we bring to the surface the
9 real issues that are facing this
10 system each and every day, that
11 sometimes kind of get ignored and we
12 continue operating in spite of.

13 So if you can, my e-mail
14 address is uep2507vp@aol.com. Feel
15 free to e-mail as lengthy of a
16 response or as short a response as
17 you'd like. But like I said, it is
18 mandatory for the chairs. I would
19 appreciate that before March 1st if
20 possible. This way we can actually
21 start doing some research and do
22 things in a public forum for the
23 June meeting and maybe get that out
24 and see what committees need to

1 start possibly new projects and have
2 all of us going in one direction.

3 Any other new business? Going
4 once, going twice. I think this is
5 a record. Yes, Mr. Quinn.

6 MR. QUINN: On a more
7 serious note, Ed mentioned that he
8 had attended our EMS conference in
9 Long Island and with Bob Delagi and
10 we want to thank him for that. I
11 understand that Don and Ed will both
12 be out in Montour Falls.

13 Our organization has put on an
14 EMS seminar for not only our
15 members, but anybody else that wants
16 to attend for the last -- this will
17 be our 27th annual meeting.

18 And several years ago with a
19 number of questions coming in from
20 the attendees about what really goes
21 on in New York State, who governs
22 us, who does this, that and the
23 other thing, we then decided to ask
24 Ed and the chair of the state

1 council to come and make a little
2 presentation, answer questions and
3 so forth at the meeting. And I want
4 to really thank everybody. I know
5 there are several past chairs in
6 this room who have been out there.
7 I want to thank them for that.

8 And I just want to repeat, and
9 maybe I said this before, a comment
10 I heard at last year or the year
11 before when one of our vendors, who
12 is from out of state, said something
13 about the conference. And I said,
14 Oh, we have the director of EMS and
15 the chair of our council now
16 speaking to our people. And this
17 person says, In our state, nobody
18 knows what the director looks like.
19 So I want to thank you for that.

20 MR. WRONSKI: You're very
21 welcome, Mike. And I'll speak for
22 the chairs. I think the chairs have
23 always liked your conference. It's
24 very well attended. It represents a

1 good cross-section of EMS. It's not
2 simply a fire conference. It's a
3 true EMS conference and it's
4 beneficial to me, sometimes
5 difficult but beneficial to hear the
6 questions that the providers have
7 directly. And hopefully we benefit
8 them and I know the chairs enjoy it
9 and enjoy this, too. Thank you.

10 MR. FAETH: Thank you.
11 Any further new business? Thank
12 you, Mr. Quinn.

13 Reminder. The next meeting
14 will be held on June 9th and 10th.
15 It will be a little warmer but we're
16 going to have a good time and get
17 some work done.

18 And I hope everyone gets home
19 safely. Take care. Thank you.

20 (Whereupon, the meeting
21 concluded at 11:57 a.m.)

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C E R T I F I C A T E .

I, Nora B. Lamica, a Shorthand Reporter and Notary Public in and for the State of New York, do hereby certify that the foregoing record taken by me is a true and accurate transcript of the same, to the best of my ability and belief.

Nora B. Lamica

Date: February 23, 2009